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	345409	A. BUILDING _____ B. WING _____	C 11/16/2023

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/13/23 through 11/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CVZD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/13/23 through 11/16/23. Event ID# CVZD11. The following intake was investigated NC00208651. 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews of residents, family, resident representative, and staff, the facility failed to provide nail care for dependent residents (Resident #s 32, 41, 45, and 50) and failed to provide hair wash for dependent residents (Resident #s 13, 32, 41, and 45) for 5 of 6 residents reviewed for activities of daily living. Findings included: 1. Resident #13 was admitted to the facility on 7/20/20 with the diagnosis of muscular weakness.	F 677	The facility provides the following Plan of Correction without admitting or denying the validity of the existence of the alleged deficiencies. The POC is prepared and/or executed as required by the provisions of federal and state law. The facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. Nail care was provided to residents # 32, 41, 45, and 50 on 11/14/23 by the certified	12/14/23

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

Electronically Signed | 12/14/2023

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F 677	Continued From page 1 Resident #13's quarterly Minimum Data Set dated 10/17/23 documented the resident was unable to participate in the brief interview for cognitive status. The resident required 2-person physical assist for bathing. There was no refusal of care. Resident #13's care plan dated 10/17/23 documented she had an activity of daily living deficit and was dependent on staff for bathing and personal care. Resident #13 was unable to be interviewed. On 11/13/23 at 2:30 pm the resident was observed in her room. The resident's hair was greasy appearing and tightly collected to the back of her head. On 11/14/23 at 11:30 am an interview was conducted with Resident #13's family member. The family member stated the resident was not getting her showers as scheduled and the resident's hair was dirty. The family member would like the resident to have her scheduled showers so she can have her hair washed. A review of the electronic bathing and shower documentation for the months of October and November 2023 revealed Resident #13 had a bed bath/sponge 3 to 5 times a week on day shift. There was no documentation of hair wash or nail care. The last bed bath was on 11/14/23. A review of Resident #13's bathing/shower paper form for the months of October and November 2023 by NA #2, the dedicated shower NA, was completed. The resident had her showers on	F 677	nursing assistants. Residents # 13, 32, 41, and 45 had their hair washed on 11/15/23 by the certified nursing assistants. A 30 day lookback was performed by the Unit Manager on 12/13/23 to ensure ADL care was completed and showers were scheduled at least twice weekly on all residents to include hair and nail care. No issues were identified. On 11/30/23-12/7/23 The Director of Nursing/designee provided reeducation to all licensed nursing staff on nail care and hair care procedures and the expectation that hair and nail care will be provided with showers/bathing and as needed or upon resident request. Any licensed staff that cannot be reached by our date of compliance will not take an assignment until they have received this reeducation by the Director of Nursing/designee. This includes any newly hired and new agency staff. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor a random sample of 10 residents to ensure ADL care is being provided to include nail and hair care. Monitoring will be done 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended	

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F 677	Continued From page 2 Tuesday and Friday. The following dates documented care received: " 10/3 bed bath instead of shower, no nails cut, no refusal " 10/5 shower, no nails, no refusal " 10/10 shower, no nails, no refusal, hair wash " 10/12 shower, no nails, no refusal " 10/17 bed bath instead of shower, no nails and no refusal " 10/19 shower, no nails, no refusal " 10/24 bed bath instead, no nail care, no refusal " 10/26 shower, no nail care, no refusal " 10/31 shower, no nail care, no refusal " 11/2 shower, no nail care, no refusal " 11/7 bed bath instead of shower, no nail care, no refusal " 11/9 bed bath instead of shower, no nail care, no refusal On 11/16/23 at 11:15 am an interview was conducted with NA #2. NA #2 stated she was the shower NA for the entire facility on day shift 11/16/23 and most weekdays (days or evenings). She stated on day shift today, 11/16/23, she had 15 residents throughout the facility to provide a shower minus any resident that refused. She stated there was not always a shower NA scheduled and the assigned NA would be responsible for showers plus the bed baths. Hair was usually washed during the shower and a few residents had the beautician wash their hair once a week. She stated a bathing/shower paper form was completed that included documentation for refusal of care, shaving, whether a resident's hair was washed, type of bathing (bed or shower), and whether nail care was completed. She stated that when the form had documented "a bed bath	F 677	by the committee.	

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instead" this would mean the resident received a bed bath instead of a shower. She was not able to state if Resident #13 had her hair washed with the bed bath on 11/9/23.

On 11/14/23 at 1:30 pm an interview was conducted with Nurse #2. Nurse #2 stated that she did not know how a resident who received a bed bath would have a hair wash. Hair was typically washed in the shower. The NA staff had not reported to Nurse #2 they were unable to wash a resident's hair.

On 11/15/23 at 9:00 am an interview was conducted with NA #3. She stated that male residents that have a bed bath would have their hair washed with a towel if the resident asked. NA #3 had no comment regarding washing female resident's hair that did not have a shower. NA #3 stated sometimes residents had a bed bath and not a shower because the shower took more time and there was not enough staff or time.

On 11/16/23 at 3:40 pm an interview was conducted with NA #4. NA #4 was assigned to the evening shift for Resident #13. She was dedicated to showers on evening shift when there was enough staff. She had a full assignment on 11/16/23 evening shift, not showers. When a bed bath was provided, the hair was not always washed. Hair could be washed with a towel in the bed. She could not remember the last time she washed a resident's hair in the bed or cut their nails.

2. Resident #32 was admitted to the facility on 12/10/18 with the diagnosis of diabetes.

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Resident #32's quarterly Minimum Data Set dated 10/17/23 documented the resident's cognition was intact. The resident was dependent for bathing. There was no refusal of care.

Resident #32's care plan dated 10/17/23 had an activity of daily living deficit and required assistance with bathing and personal care.

A review of the electronic bathing and shower documentation for the months of October and November 2023 revealed Resident #32 had a bed bath/sponge 3 to 5 times a week on day shift. There was no documentation of hair wash or nail care. The last bed bath was on 11/15/23.

A review of Resident #45's bathing/shower paper form for the months of October and November 2023 by Nursing Assistant (NA) #2, the dedicated shower NA, was completed. The resident had his showers on Tuesday and Friday. The following dates documented care received:

" 10/3/23 Refused shower and no other care provided, nurse notified
" 10/6/23 Refused shower and no other care provided, nurse notified
" 10/10/23 Refused shower and no other care provided, nurse notified
" 10/13/23 Refused shower and no other care provided, nurse notified
" 10/17/23 Refused shower and no other care provided, nurse notified
" 10/20/23 Refused shower and no other care provided, nurse notified
" 10/24/23 Refused shower and no other care provided, nurse notified
" 10/27/23 Refused shower and no other care

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provided, nurse notified
" 10/31/23 Refused shower and no other care provided, nurse notified
" 11/3/23 Refused shower and no other care provided, nurse notified
" 11/10/23 Refused shower and no other care provided, nurse notified
" 11/14/23 Refused shower and no other care provided, nurse notified

On 11/13/23 at 11:20 am Resident #32 was observed and interviewed. The resident had dirty hair (flat to the scalp) and long dirty nails. The resident stated he was too large for the shower gurney and cannot take a shower because he was afraid. The resident stated he had not had his hair washed in a long time.

On 11/16/23 at 11:30 am an interview was conducted with the Administrator. He stated that there was a shower gurney for large residents that would hold Resident #32. He thought the bed bath was a preference.

On 11/14/23 at 1:00 pm Resident #32 was observed and interviewed. The resident had dirty hair and long, dirty nails. The resident stated he asked NA #2 this morning to wash his hair and she was not able to due to her assignment. He was informed by NA #2 there was not enough time.

On 11/16/23 at 11:15 am an interview was conducted with NA #2. NA #2 stated she was the shower NA for the entire facility on day shift 11/16/23 and most weekdays (days or evenings). She stated on day shift today, 11/16/23, she had 15 residents throughout the facility to provide a

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shower minus any resident that refused. She stated there was not always a shower NA scheduled and the assigned NA would be responsible for showers plus the bed baths. Resident's hair was usually washed during the shower. She stated a bathing/shower paper form was completed that included documentation for refusal of care, shaving, whether a resident's hair was washed, type of bathing (bed or shower), and whether nail care was completed. She was not able to state if Resident #32 had his hair washed with his bed bath on 11/14/23. She also had no statement about the resident's long, dirty nails.

On 11/14/23 at 1:20 pm an interview was conducted with Nurse #2. Nurse #2 stated that she did not know how a resident who received a bed bath would have a hair wash in the bed. Hair was usually washed in the shower. She stated that the NA was required to provide the residents with nail care. If the NA was unable or the resident refused, the nurse was required to be informed.

Nurse Manager #1 was interviewed on 11/14/23 at 1:30 pm. She stated NAs were required to cut resident's nails and if unable to cut the nails to inform the nurse.

On 11/15/23 at 9:00 am an interview was conducted with NA #3. She stated that male residents that have a bed bath would have their hair washed with a towel to protect the bed if the resident asked. NA #3 stated sometimes residents had a bed bath and not a shower because the shower took more time and there was not enough staff.

On 11/16/23 at 3:40 pm an interview was

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conducted with NA #4. NA #4 was assigned to the evening shift for Resident #32. She was dedicated to showers on evening shift when there was enough staff. She had a full assignment on 11/16/23 not showers. NA #4 stated she provided only bed baths for Resident #32. When a bed bath was provided, the hair was not always washed. Hair could be washed with a towel in the bed. She could not remember the last time she washed a resident's hair in the bed or cut their nails. NA #4 was not sure if Resident #32 had long or dirty nails and would check.

3. Resident #41 was admitted to the facility on 6/12/20 with the diagnosis of traumatic brain injury.

A review of Resident #41's care plan dated 7/27/23 documented he had an activity of daily living deficit and required bathing and nail care assistance.

Resident #41's quarterly Minimum Data Set dated 7/27/23 documented the resident's cognition was intact and required partial/moderate assistance with personal care. There was no refusal of care.

A review of the shower schedule at the nurses' station revealed residents were scheduled twice a week Monday through Saturday to receive a shower. Resident #41 was scheduled for Tuesday and Thursday.

A review of Resident #41's bathing/shower paper form for the months of October and November 2023 revealed he had refused a shower signed by Nursing Assistant (NA) #2 on 10 occasions and the nurse was notified on 8 occasions. There was no documentation of nail care or facial shave

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on the form.

A review of the electronic bathing and shower documentation for the months of October and November 2023 revealed Resident #41 had a bed bath/sponge 2 to 4 times a week. There was no documentation of hair wash or nail care.

On 11/13/23 at 2:48 pm an observation was completed of Resident #41 in his bed. He had long fingernails (1/4 inch) with brown soil underneath and his hair appeared to be greasy. During concurrent interview with the resident, he stated he would like his fingernails cut and cleaned. The resident commented that he was receiving a bed bath and his hair had not been washed in a while, more than a week, and he would like his hair washed. He stated that he asked the staff (could not remember who) to wash his hair, but it was not done.

On 11/14/23 at 1:15 pm an observation was completed of Resident #41 with Unit Manager #1. The resident's nails were cut but still had soil that was not removed with cutting and his hair had not been washed. The Unit Manager stated she cut the resident's nails this morning and stated the nails had not been cut in a while and the Nursing Assistant (NA) was responsible unless the resident had a diabetic diagnosis or the resident refused then the assigned nurse would be notified.

On 11/15/23 at 9:20 am an interview was conducted with Nurse #5. Nurse #5 stated today was his second day working at the facility. He was not aware any residents needed their hair washed and nail care.

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On 11/15/23 at 9:30 am an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated there was a resident shower schedule book at the nurses' station but she had not looked at the schedule this morning and had not known who had a shower scheduled on her assignment today (11/15/23). NA #3 stated there were times when there was not enough staff or time to give scheduled showers and a bed bath was given. NA #3 stated she could use a towel to wash a male's hair but was not sure how she would wash long hair during the bed bath. NA #3 could not remember the last time she had cut a resident's nails; it had been a while.

On 11/15/23 at 9:55 am an interview was conducted with NA #1. NA #1 stated when there was not a dedicated shower NA assigned, the staff NA would provide bed baths to residents scheduled for a shower on day or evening shift. Hair washing was not always accomplished during this time. NAs were required to cut resident's nails if he/she had no diabetic diagnosis. If the NA was unable to cut the resident's nails, the nurse would be informed. Hair washing could be accomplished using a towel in the bed. NA #1 had no comment regarding how to wash long hair with a towel in a resident's bed. NA #1 stated she could not remember the last time she cut a resident's fingernails, but she regularly cleaned them with a washcloth to remove soil, but this was easier in the shower.

On 11/16/23 at 11:15 am an interview was conducted with NA #2. NA #2 stated she was the shower NA for the entire facility on day shift today, 11/16/23. She had 15 residents throughout the facility to provide a shower minus any resident

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that refused. She stated there were always refusals and could finish her assignment. She stated there was not always a shower NA scheduled and the assigned NA would be responsible for showers plus the bed baths. Hair was usually washed during the shower and a few residents had the beautician wash the hair once a week. She stated a bathing/shower paper form was completed that included documentation for refusal of care, whether a resident's hair was washed, type of bathing (bed or shower), and whether nail care was completed. NA #2 was not able to state if Resident #41 had his hair washed with the bed bath.

An interview was conducted on 11/16/23 at 3:02 pm with NA #2. NA #2 stated residents that received a bed bath could request their hair be washed, if unable to request, staff would determine it would need to be done. Hair wash was not always completed with the bed bath.

On 11/16/23 at 3:40 pm an interview was conducted with NA #4. NA #4 stated she was assigned to the evening shift for Resident #41. She was usually dedicated to showers on evening shift when there was enough staff. She had a full assignment today (11/16/23) not showers. NA #4 stated she provided only bed baths for Resident #41. When a bed bath was provided, the hair was not always washed. Hair could be washed with a towel in the bed. She could not remember the last time she washed a resident's hair in the bed or cut their nails. NA #4 was not sure if Resident #41 had long or dirty nails and would check.

4. Resident #45 was admitted to the facility on 1/4/19 with the diagnosis of diabetes and

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impaired vision.

The quarterly Minimum Data Set dated 9/22/23 documented Resident #45's had a memory deficit. The resident was dependent for bathing and personal care. There was no refusal of care.

Resident #45's care plan dated 9/22/23 documented he had an activity of daily living deficit and was dependent on staff for all care except eating due to lack of mobility and vision deficit.

On 11/13/23 at 1:09 pm an observation was completed of Resident #45 in his bed. His hair was greasy and segmented with white dandruff and long, dirty nails (greater than ¼ inch). The left hand, second fingernail was jagged with black soil and skin to the end of the nail. The resident's use of his fingers on both hands appeared stiff but he was able to hold a fork and spoon to independently eat his lunch meal. Concurrent interview with the resident was done and he stated the staff had not provided him with a shower, he received a bath in the bed and had not known when his hair was last washed. The resident stated "I am blind and cannot see" that his nails were dirty. The resident touched his face and commented that he would like his face shaved.

On 11/14/23 at 9:45 am an interview was conducted with Resident #45's Representative. She stated during visits the resident was observed to not have gotten bathed, showered, hair washed, nail care, dressed in clothes, nor facial hair shave. She noticed body odor and he was frequently dressed in a hospital gown. She stated staff was informed of the resident's

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condition. The Representative wanted the resident to have a shower so he could get his hair washed.

A review of the electronic bathing and shower documentation for the months of October and November 2023 revealed Resident #45 had a bed bath/sponge 3 to 5 times a week on day shift. There was no documentation of hair wash or nail care.

A review of Resident #45's bathing/shower paper form for the months of October and November 2023 by Nursing Assistant (NA) #2, the dedicated shower NA, was completed. The resident had his showers on Monday and Wednesday. The following dates documented care received:
" 10/2/23 Shower, shaved, nails clipped/cleaned
" 10/4/23 Shower, shaved, nails clipped/cleaned
" 10/9/23 Shower, shaved, nails clipped/cleaned
" 10/11/23 Shower, shaved, nails clipped/cleaned
" 10/16/23 Shower, shaved, nails clipped/cleaned
" 10/18/23 Shower, shaved, nails clipped/cleaned
" 10/23/23 Shower, shaved, nails clipped/cleaned
" 10/25/23 no care on (shower) evenings, received a bed bath on 3rd shift
" 10/30/23 Bed bath, shaved, nails clipped/cleaned
" 11/6/23 Hospital
" 11/8/23 Hospital
" 11/13/23 no care (shower) on evenings, received a bed bath on 3rd shift

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On 11/16/23 at 11:15 am an interview was conducted with NA #2. NA #2 stated she was the shower NA for the entire facility on day shift 11/16/23 and most weekdays (days or evenings). She stated on day shift today, 11/16/23, she had 15 residents throughout the facility to provide a shower minus any resident that refused. She stated there was not always a shower NA scheduled and the assigned NA would be responsible for showers plus the bed baths. Hair was usually washed during the shower and a few residents had the beautician wash their hair once a week. She stated a bathing/shower paper form was completed that included documentation for refusal of care, shaving, whether a resident's hair was washed, type of bathing (bed or shower), and whether nail care was completed. She stated that when the form had documented "a bed bath instead" this would mean the resident received a bed bath instead of a shower. She was not able to state if Resident #45 had his hair washed with the bed bath 11/13/23. She also had no statement about the resident's long, dirty nails which had skin underneath and were not able to be cut by Unit Manager #1, but she documented the resident had his nails cut/cleaned on 8 of the 9 occasions she provided a shower.

On 11/14/23 at 1:50 pm Resident #45 was observed and interviewed with Unit Manager #1. The resident had approximately five of his fingernails on both hands cut by the Manager this morning but were still long due to growth of skin under the nail ends. The nails remained dirty underneath with black soil, including the left second fingernail that was jagged and had skin growth to the end of the nail which could not be cut. The Manager observed that the resident's

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hair was dirty with segmented greasy appearance. During concurrent interview with the Manager, she stated the resident's skin had grown underneath his long fingernails and she would not be able to cut this morning. The Manager made no mention of cleaning the nails or hair and how to manage the resident's skin that had grown up underneath the long nails. The Manager further stated she was not aware the nails were not getting cut and scheduled the NA to provide the resident with a shower and hair wash.

On 11/14/23 at 3:30 pm an interview was conducted with Unit Manager #1. She stated Resident #45 had a consultation ordered for a dermatologist to evaluate the overgrowth of skin under the fingernails and trim.

On 11/15/23 at 9:30 am an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated there was a resident shower schedule book at the nurses; station but she had not looked at the schedule this morning and had not known who had a shower scheduled on her assignment today (11/15/23). NA #3 stated there were times when there was not enough staff or time to give scheduled showers and a bed bath was given. NA #3 stated she could use a towel to wash a resident's hair. NA #3 could not remember the last time she had cut a resident's nails; it had been a while. NA #3 further stated she would not cut nails for residents with a diabetic diagnosis. This was the responsibility of the nurse.

On 11/15/23 at 9:55 am an interview was conducted with NA #1. NA #1 stated when there was not a dedicated shower NA assigned, the

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staff NA would provide bed baths to residents scheduled for a shower on day or evening shift. Hair washing was not always accomplished during this time. NAs were required to cut resident's nails if he/she had no diabetic diagnosis. If the NA was unable to cut the resident's nails, the nurse would be informed. Hair washing could be accomplished using a towel in the bed. NA #1 stated she could not remember the last time she cut a resident's fingernails, but she regularly cleaned them with a washcloth to remove soil, but this was easier in the shower.

On 11/16/23 at 3:40 pm an interview was conducted with NA #4. NA #4 was assigned to the evening shift for Resident #41. She was dedicated to showers on evening shift when there was enough staff. She had a full assignment on 11/16/23 evening shift, not showers. NA #4 stated she provided only bed baths for Resident #41. When a bed bath was provided, the hair was not always washed. Hair could be washed with a towel in the bed. She could not remember the last time she washed a resident's hair in the bed or cut their nails. NA #4 was not sure if Resident #41 had long or dirty nails and would check.

5. Resident #50 was admitted to the facility on 7/21/20 with the diagnosis of stroke.

Resident #50's quarterly Minimum Data Set dated 10/23/23 documented he had an intact cognition. The resident was dependent for bathing. There was no refusal of care.

Resident #50's care plan dated 10/23/23 documented an activity of living deficit, and he

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required assistance with personal care and bathing.

A review of Resident #50's bathing/shower paper form documentation for the months of October and November 2023 by Nursing Assistant (NA) #2, the dedicated shower NA, was completed. The resident had his showers on Monday and Thursday. The following dates documented care received:
" 10/2/23 Shower, shaved and nails clipped/cleaned
" 10/5/23 Shower, shaved and nails clipped/cleaned
" 10/9/23 Shower, shaved and nails clipped/cleaned
" 10/12/23 Shower, shaved and nails clipped/cleaned
" 10/16/23 Shower, shaved and nails clipped/cleaned
" 10/19/23 Shower, shaved and nails clipped/cleaned
" 10/23/23 Shower
" 10/26/23 Shower, shaved and nails clipped/cleaned
" 10/30/23 Shower, shaved and nails clipped/cleaned
" 11/2/23 Shower, shaved and nails clipped/cleaned
" 11/6/23 Refused care, nurse notified
" 11/9/23 Shower, shaved, and nails clipped/cleaned
" 11/13/23 Shower, shaved, and nails clipped/cleaned

A review of the electronic bathing and shower documentation for the months of October and November 2023 revealed Resident #50 had a bed bath/sponge 2 to 3 times a week on day shift.

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Last bed bath was on 11/13/23. There was no documentation of hair wash or nail care. There is documentation of nail care above. I don't think the documentation is accurate, but it does exist.

On 11/13/23 at 3:58 pm an observation and interview was completed of Resident #50. The resident had long-dirty nails with brown soil underneath and some nails were jagged. The resident's facial hair was long and course. The resident stated he had not had his nails cut and would like them cut. The resident could not remember the last time he had nail care.

On 11/14/23 at 1:30 pm Resident #50 was observed, and his hygiene remained the same.

On 11/15/23 at 12:30 pm Resident #50 was observed and interviewed with Unit Manager #1. The resident had his beard trimmed and hair washed and cut at the facility beautician and his nails were cut by the Manager today, but they remained dirty underneath the nail with brown soil. The Manager stated she cut the resident's nails this morning, the nails had not been cut in a while, and the NA was responsible unless the resident had a diabetic diagnosis, or the resident refused then the assigned nurse would be notified.

On 11/15/23 at 9:30 am an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated there were times when there was not enough staff or time to provide nail care. NA #3 could not remember the last time she had cut a resident's nails; it had been a while. NA #3 further stated she would not cut nails for residents with a diabetic diagnosis. This was the responsibility of the nurse.

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F 677	Continued From page 18 On 11/15/23 at 9:55 am an interview was conducted with NA #1. NA #1 stated when there was not a dedicated shower NA assigned, the staff NA would provide bed baths and nail care. NAs were required to cut resident's nails if he/she had no diabetic diagnosis. If the NA was unable to cut the resident's nails, the nurse would be informed. NA #1 stated she could not remember the last time she cut a resident's fingernails, but she regularly cleaned them with a washcloth to remove soil, but this was easier in the shower. On 11/16/23 at 11:15 am an interview was conducted with NA #2. NA #2 stated she was the shower NA for the entire facility on day shift 11/16/23. She stated today 11/16/23 she had 15 residents throughout the facility to provide a shower, hair wash and nail care minus any resident that refused. She stated there was not always a shower NA scheduled and the assigned NA would be responsible for resident care. She stated a bathing/shower paper form was completed that included documentation for refusal of care and whether nail care was completed. On 11/16/23 at 3:40 pm an interview was conducted with NA #4. NA #4 was assigned to the evening shift for Resident #50. She was dedicated to showers on evening shift when there was enough staff. She had a full assignment on 11/16/23 evening shift, not showers. She could not remember the last time she cut a resident's nails. NA #4 was not sure if Resident #50 had long or dirty nails and would check.	F 677		
F 697 SS=E	Pain Management CFR(s): 483.25(k)	F 697		12/14/23

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F 697	Continued From page 19 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacy Manager, Nurse Practitioner, and the Medical Directors interviews the facility failed to provide pain management by a.) not administering an as needed dose of the opioid medication Oxycodone prescribed for pain to a resident (Resident #222) who experienced frequent pain and b.) not following up with the Pharmacy regarding the anticonvulsant medication Lyrica prescribed three times a day for pain which resulted in the resident not receiving 11 doses of the medication and having complaints of pain for 1 of 1 resident (Resident #222) reviewed for pain management. Findings included. Resident #222 was admitted to the facility on 09/20/23 with diagnoses including Fibromyalgia (a disorder characterized by widespread musculoskeletal pain), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Chronic Kidney Disease, and Left below knee amputation. The baseline care plan for Resident #222 dated 09/20/23 did not include pain management with goals and interventions. a.) A progress note dated 09/20/23 at 02:17 PM revealed Resident #222 was admitted at 1:45 PM from the hospital with oxygen at 3LPM (liters per	F 697	Resident 222 No longer resides at the facility. A 30 day lookback was performed by the Director of Nursing/designee on 12/13/23 to identify if any residents experiencing documented pain was addressed by non pharmological interventions or by administering prescribed pain medication as ordered by the Physician. There were no issues identified. A 30 day lookback was performed by the Director of Nursing/designee on 12/13/23 to verify that medications ordered were delivered by the Pharmacy and administered per Physician orders. No issues were identified. On 11/30/23-12/7/23 the Director of Nursing/designee provided reeducation to all licensed nurses on the policy of pain management and the procedure for what to do when medications are not available and the expectation that the Physician will be notified if there is a medication not available for further orders and direction. Any licensed nurses that cannot be reached by our date of compliance will not take an assignment until they have received this reeducation by the Director	

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F 697	Continued From page 20 minute). He was alert and oriented to person, place, and time. He had no acute pain noted on admission. The hospital discharge summary dated 09/20/23 revealed Resident #222 had an order for Oxycodone 10 milligrams (mgs) give two times a day as needed for pain for 5 days. The Minimum Data Set (MDS) 5-day assessment dated 09/25/23 revealed Resident #222 was cognitively intact. He required extensive two-person assistance with bed mobility, transfers, and activities of daily living. He received scheduled pain medications and experienced frequent pain. His pain intensity rating was 5 on a scale of 10 at the time of the assessment. He received opioids on 3 of 7 days. Review of the pain rating scale for Resident #222 was as follows: On 09/20/23 at 03:43 PM Resident #222 had a pain rating of 5 on a scale of 10. This was documented by Nurse #1. On 09/21/23 at 04:24 AM Resident #222 had a pain rating of 9 on a scale of 10. This was documented by Nurse #2. On 09/22/23 at 02:07 AM Resident #222 had a pain rating of 7 on a scale of 10. This was documented by Nurse #3. On 09/22/23 at 09:26 AM Resident #222 had a pain rating of 4 on a scale of 10. This was documented by Nurse #1. On 09/22/23 at 05:55 PM Resident #222 had a	F 697	of Nursing/designee. This includes any newly hired and new agency staff. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor in the clinical morning meeting 5x weekly to verify that any complaints of pain were addressed and documented in the medical record and the Physician was notified if the medication was not available. Monitoring will be done 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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pain rating of 7 on a scale of 10. This was documented by Nurse #3.

On 09/23/2023 at 02:13 AM Resident #222 had a pain rating of 8 on a scale of 10. This was documented by Nurse #3.

Review of the Medication Administration Record (MAR) dated September 2023 for Resident #222 revealed Oxycodone 10 mgs prescribed as needed for pain was not administered to Resident #222 at any time from 09/20/23 through 09/23/23 at 5:54 AM.

Review of the Controlled Medication Record for Resident #222 revealed the first dose of Oxycodone was administered to Resident #222 on 09/23/23 at 05:54 AM by Nurse #3.

Review of the progress notes for Resident #222 revealed no documentation that any pain medication was administered from 09/20/23 until the first dose of Oxycodone was administered on 09/23/23 at 05:54 AM.

Review of the progress notes revealed Resident #222 was discharged to the hospital on 09/25/23 due to shortness of breath related to COPD exacerbation.

A progress note dated 10/05/23 at 11:06 PM documented by Nurse #4 revealed Resident #222 readmitted from the hospital. His vital signs were stable, and he had no complaints of pain.

A physicians order dated 10/06/23 at 2:14 PM revealed Resident #222 was prescribed Oxycodone oral tablets 10 mgs. Give 1 tablet by mouth every 12 hours as needed for pain.

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A progress note dated 10/06/23 at 7:15 PM documented by Nurse #5 revealed in part; Resident #222 had complaints about pain medications but goes to the pain control center and we had to wait until it came from pharmacy.

Review of the pain rating scale for Resident #222 dated 10/06/23 at 8:05 PM revealed a pain rating of 5 out of 10. This was documented by Nurse #8.

Review of the Medication Administration Record (MAR) dated October 2023 for Resident #222 revealed Oxycodone 10 mgs prescribed as needed for pain was not administered to Resident #222 at any time on 10/06/23.

Review of the Controlled Medication Record for Resident #222 revealed the first dose of Oxycodone was administered to Resident #222 on 10/07/23 at 02:15 AM by Nurse #4.

Review of the progress notes for Resident #222 revealed no documentation that pain medication was administered on 10/06/23.

During a phone interview on 11/16/23 at 02:07 PM Nurse #1 stated Resident #222 was very frail and had respiratory issues and he didn't recall him having frequent complaints of pain. He stated Resident #222 was getting scheduled Lyrica for pain but didn't remember giving him any as needed medications such as Oxycodone. He stated Resident # 222 had phantom pain and Nurse #1 thought that Lyrica could manage his pain. He stated Resident # 222 didn't really complain of pain often to him. He stated if Resident #222 had significant complaints of pain, he would have notified the Physician. He stated

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he didn't recall documenting a pain scale of 4 or 5 for Resident # 222 and indicted he didn't recall going to the Omnicell (the onsite medication dispensing system) to get a dose of Oxycodone to administer to Resident # 222 for pain.

During a phone interview on 11/16/23 at 03:15 PM Nurse #2 stated Resident #222 required breathing treatments and received oxygen. She indicated she did not recall documenting a pain scale of 9 during his first admission in September. She indicated during the second admission the Oxycodone was scheduled and not just administered as needed. She stated Resident #222 would tell her that he was starting to hurt 1-2 hours before the scheduled Oxycodone was due again. She stated Resident # 222 would not take Tylenol, and stated he was not a big complainer. She stated if a Resident had unrelieved pain and no pain medication on the medication cart, she would call the on-call provider to see if they would send a hard script to the Pharmacy. She stated only a certain nurse had access to the Omnicell, but she was not sure of the process to get medications from the Omnicell. She stated she did not have access to the Omnicell and would not have been able to get an as needed dose from the Omnicell to administer to Resident # 222.

During an interview on 11/14/23 at 04:05 PM Nurse #3 stated she was the assigned nurse when Resident # 222 was initially admitted. She stated Resident # 222 was alert and oriented and could voice his needs. She stated she arrived for her shift at 7:00 PM that night and Resident # 222 was complaining of pain when she came on shift. She stated his pain scale was maybe 7 or 8 on a scale of 10, so she offered Tylenol, but he told

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her Tylenol did not control his pain. She stated he complained of generalized pain. She stated she did not have access to the Omnicell and stated she didn't know that Oxycodone was in the Omnicell and available for administration to Resident # 222 . She stated she didn't ask another nurse to assist her in getting into the Omnicell to get the pain medication for Resident # 222 . She stated she may be confusing the initial admission date with the readmission date on 10/06/23 but stated Resident # 222 did have complaints of pain. She stated the Oxycodone was not on the medication cart at the time that he had complaints of pain, and they were waiting for his medications to come from the Pharmacy and thought the Oxycodone would come in later that night. She stated sometimes Pharmacy doesn't make their delivery until 1:00 - 2:00 AM in the morning. She stated she recalled giving Resident # 222 Oxycodone early one morning when it came in from the pharmacy. She indicated she could have asked another nurse to assist her in getting the medication from the Omnicell to administer to Resident # 222 but she didn't know to do that.

During a second phone interview on 11/16/23 at 11:57 AM Nurse #3 stated she had never been in a situation when there were no pain medications available for a Resident. She stated she never had to deal with pharmacy but knew Resident # 222 had Oxycodone ordered but couldn't remember if she spoke to Pharmacy about the Oxycodone. She stated usually when a medication had been ordered and was not there within 1-2 day she always tried to follow up with Pharmacy. She stated she knew of the Omnicell, but she did not know the Omnicell held narcotics. She stated she knew the process to get

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medications from the Omnicell but not the process to get narcotics from the Omnicell. She stated when Resident # 222 had complaints of pain she didn't know of anything different that could have been done on nights to manage his pain better. She stated no one had reported to her any information regarding Resident #222's issue regarding getting his medications. She stated Resident # 222 did mention not getting his Oxycodone, but stated she didn't know anything else to do at that time.

Attempts were made to contact Nurse #4 and #5. There was no response.

During an interview on 11/14/23 at 4:30 PM the Director of Nursing (DON) stated when a resident was admitted to the facility with an order for a controlled substance and did not have a hard script for the controlled medication, they would have to contact the Case Manager at the hospital or discharging facility to have the physician send a hard script to the Pharmacy. She stated their Physician would not write a hard script for a controlled medication if the Physician had not evaluated the resident. She stated they usually try to have the Case Manager from the discharging facility fax a list of the residents medications prior to the resident getting admitted to the facility. She stated the delay in getting the Oxycodone for Resident #222 was most likely due to having to contact the hospital to get a hard script. She stated once the Pharmacy received the hard script, they would send the controlled medication in the daily delivery to the facility. She stated Resident # 222 did not go to a pain clinic. She stated all nurses had access to the Omnicell and indicated the nurses could have retrieved and administered Oxycodone if Resident # 222 had

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complaints of pain during the time they were waiting for the medication to come from Pharmacy.

A phone interview was conducted on 11/15/23 at 3:00 PM with the Pharmacy Manager. She stated for new admissions a hard script must be provided before a controlled medication could be filled. She stated hard scripts could be faxed to the Pharmacy or the Physician could call in an emergency script for up to a 72-hour supply of Oxycodone. She stated the Pharmacy did not solicit prescriptions and that it would be the responsibility of the facility to get a hard script sent to the Pharmacy. She stated on Resident #222's first admission the Pharmacy received the hard script for Oxycodone on 09/22/23 at 5:41 PM and dispensed the medication on the 10:00 PM delivery that night and the medication arrived at the facility at 2:27 AM on 9/23/23. She stated this facility owned their narcotics and had Oxycodone 5 milligrams stocked in the Omnicell so the medication could have been removed from the Omnicell between the time of admission until the Oxycodone was received from the Pharmacy without having to call the Pharmacy.

Multiple attempts were made to contact Resident #222 during the investigation. There was no response.

b.) Review of Resident #222's medical record revealed he was discharged to the hospital on 09/25/23 due to shortness of breath related to COPD exacerbation. He was readmitted to the facility on 10/05/23.

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Review of the hospital discharge summary dated 10/05/23 revealed Resident #222 had an order for Pregabalin (Lyrica) 200 mgs give three times a day for pain.

Review of the MAR dated October 2023 revealed Resident #222 did not receive the scheduled doses of Lyrica from 10/06/23 through 10/10/23. This resulted in 11 missed doses of the medication.

Review of the progress notes dated 10/06/23 through 10/10/23 revealed no documentation as to why the medication Lyrica had not been received and administered to Resident #222.

A progress note dated 10/10/23 at 04:41 AM documented by Nurse #3 revealed in part; Resident # 222 was able to make his needs known. Resident #222 stated he was in pain. The Pharmacy was called about Resident # 222s Lyrica. The pharmacy stated to call back on day shift.

A progress note dated 10/10/23 revealed Resident #222 was discharged to the hospital due to shortness of breath related to COPD exacerbation.

A phone interview was conducted on 11/15/23 at 3:00 PM with the Pharmacy Manager. She stated the Pharmacy received 3 prescriptions for Resident # 222's Lyrica between 09/21/23 through 10/06/23. She stated that when Resident #222 discharged to the hospital on 09/25/23 his Lyrica was returned by the facility and sent for destruction because it was a controlled medication. She stated when the new order was

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sent to the Pharmacy on 10/06/23 it was rejected because it was an early refill. She stated the facility could have called the Pharmacy sooner to get an override and the Lyrica could have been sent sooner. She stated the Pharmacy did not receive a call until 10/10/23 regarding the medication and it was sent to the facility on 10/11/23. She stated it was unfortunate and could have been clarified sooner with a phone call. She stated Lyrica could have been retrieved from the Omnicell, but it would not have been for the full dose. She stated she could not say for certain what signs or symptoms Resident # 222 would potentially have from not receiving Lyrica but stated it was typically prescribed for neuropathic pain.

During a phone interview on 11/16/23 at 11:57 AM Nurse #3 stated Resident #222 was asking for Lyrica and she told him it was not on the medication cart, so she called the Pharmacy. She stated Resident #222 had complaints of generalized pain. She stated the Pharmacy stated the medication may be stuck in limbo and for her to call back on day shift. She did not recall reporting to day shift to call Pharmacy regarding the Lyrica. She indicated Resident # 222 was sent back out to the hospital before the medication was received in the facility.

During an interview on 11/16/23 at 2:00 PM the Nurse Practitioner stated she was not aware Resident #222 did not receive the scheduled Lyrica during his second admission. She stated she evaluated him only once on 10/09/23 when he was having respiratory distress. She stated during that time he did not have complaints of pain but complained of chest tenderness. She

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stated he was sent out to the hospital on 10/10/23 and did not return to the facility.

During a phone interview on 11/16/23 at 03:15 PM Nurse #2 stated there was an issue with Resident #222's Lyrica and stated each time she asked about the Lyrica she was told it was coming in that night in the Pharmacy delivery. She stated she didn't recall Resident #222 asking for Lyrica, but he would say " I'm aching". She stated she was not aware that Resident #222 did not receive any of the Lyrica prior to being sent back out to the hospital. She indicated she did not try to call the Pharmacy because she thought the medication would be delivered.

During a phone interview on 11/16/23 at 4:00 PM the Medical Director stated he was not aware Resident #222 did not receive the scheduled doses of Lyrica on his second admission in October 2023. . He stated the medication was used to assist in controlling neurogenic pain, and stated it needed to be given to Resident #222 three times a day according to the order. . He stated there would be no long-term consequences from not receiving 11 doses. He stated residents were already compromised that's why they were in this setting and pain management was a high priority. He stated the absence of the medication would not have long term effects on Resident #222, but stated Resident #222 would have the memory of not getting the pain medication.

During an interview on 11/16/23 at 4:30 PM the Director of Nursing (DON) stated she was new to the role as the Director of Nursing. She stated

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F 697	Continued From page 30 she was not aware of an issue with Resident #222's Lyrica but indicated the nursing staff should have notified the Pharmacy sooner regarding Resident #222 not having Lyrica in order to provide better pain management.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		12/14/23

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F 755	Continued From page 31 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and the Pharmacy Managers interviews the facility failed to obtain a medication (Lyrica) prescribed for pain from the Pharmacy resulting in the resident not receiving 11 doses of the medication for 1 of 1 resident (Resident #222) reviewed for the provision of pharmacy services. Findings included. Resident #222 was admitted to the facility on 09/20/23 with diagnoses including Fibromyalgia (a disorder characterized by widespread musculosketal pain), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Chronic Kidney Disease, and Left below knee amputation. A physicians order dated 09/20/23 for Resident #222 revealed Pregabalin (Lyrica) Oral Capsule 200 milligrams (mgs). Give 1 capsule by mouth three times a day for pain. Review of Resident #222s Medication Administration Record (MAR) dated September 2023 revealed he received Lyrica three times a day from 09/22/23 through 09/25/23. The Minimum Data Set (MDS) 5-day assessment dated 09/25/23 revealed Resident #222 was cognitively intact. He required extensive two-person assistance with bed mobility, transfers, and activities of daily living. He received scheduled pain medications and experienced frequent pain. His pain intensity rating was 5 on a scale of 10 at the time of the assessment.	F 755	Resident 222 No longer resides at the facility A 30 day lookback was performed by the Director of Nursing/designee on 12/13/23 to verify that medications ordered by the Physician were delivered by the Pharmacy and administered per Physician orders. No issues were identified. On 11/30/23-12/7/23 the Director of Nursing/designee provided reeducation to all licensed nurses on the procedure for what to do when medications are not available and the expectation that the Physician will be notified if there is a medication not available to obtain further orders and direction. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor in the clinical morning meeting 5x weekly to verify the Physician was notified for further orders and direction if any medication was not available. Monitoring will be done 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks with a completion date of 3/2 2024. Any licensed nurses that cannot be reached by our date of compliance will not take an assignment until they have received this reeducation by the Director of Nursing/designee. This includes any newly hired and new agency staff. The Director of Nurisng will report the	

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F 755	Continued From page 32 Review of Resident #222's medical record revealed he was discharged to the hospital on 09/25/23 due to shortness of breath related to COPD exacerbation. He was readmitted to the facility on 10/05/23. Review of the hospital discharge summary dated 10/05/23 revealed Resident #222 had an order for Pregabalin (Lyrica) 200 milligrams give three times a day for pain. Review of the Medication Administration Record (MAR) dated October 2023 revealed Resident #222 did not receive the scheduled doses of Lyrica from 10/06/23 through 10/10/23. This resulted in 11 missed doses of the medication. Review of the progress notes dated 10/06/23 through 10/10/23 revealed no documentation as to why the medication Lyrica had not been received and administered to Resident #222. A phone interview was conducted on 11/15/23 at 3:00 PM with the Pharmacy Manager. She stated the Pharmacy received 3 prescriptions for Resident #222's Lyrica between 09/21/23 through 10/06/23. She stated that when Resident #222 discharged to the hospital on 09/25/23 his Lyrica was returned to the Pharmacy by the facility and then it was sent for destruction because it was a controlled medication. She stated when the new order was sent to the Pharmacy on 10/06/23 it was rejected because it was an early refill. She stated when a medication was rejected due to being an early refill the facility received notification through fax that it was too soon to	F 755	results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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refill. She stated any time an early refill notice was sent to a facility the facility would need to call the Pharmacy and they could override and get the medication refilled so that the Resident would not have a delay in getting their medication. She stated the Pharmacy received a call from the facility on 10/10/23 regarding the medication and it was sent to the facility on 10/11/23.She stated the facility could have called the Pharmacy sooner to get an override and the Lyrica could have been sent sooner. She stated it was unfortunate and could have been clarified sooner with a phone call. She indicated the delay in getting the medication sent to the facility could have been avoided.

During a phone interview on 11/16/23 at 11:57 AM Nurse #3 stated Resident #222 was asking for Lyrica, and she told him it was not on the medication cart, so she called the Pharmacy, but she could not recall the date of the phone call. The Pharmacy stated the medication may be stuck in limbo and for her to call back on day shift. She indicated she did not recall if she notified day shift to call the Pharmacy back about the Lyrica. She indicated she thought Resident #222 was sent back out to the hospital before the medication was received in the facility.

During a phone interview on 11/16/23 at 03:15 PM Nurse #2 stated there was an issue with Resident #222's Lyrica and stated each time she asked about the Lyrica she was told it was coming in that night in the Pharmacy delivery. She stated she didn't recall Resident # 222 asking for Lyrica, but he would say " I'm aching". She stated she was not aware that Resident #222 did not receive any of the Lyrica prior to being

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F 755	Continued From page 34 sent back out to the hospital. She indicated she did not try to call the Pharmacy because she thought the medication would be delivered. During an interview on 11/16/23 at 4:30 PM the Director of Nursing (DON) stated she was new to the role as the Director of Nursing. She stated she was not aware of an issue with Resident #222's Lyrica but indicated the nursing staff should have notified the Pharmacy sooner regarding Resident #222 not having Lyrica. She stated education on following the procedures for obtaining medications from the Pharmacy would be provided.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the 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	F 761		12/14/23

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F 761	Continued From page 35 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 record an opened date on multi dose oral inhalers and record an opened date on ophthalmic drops on 3 of 3 medication carts reviewed for medication storage. Findings included. An observation of the 300/400 hall medication carts on 11/13/23 at 12:00 PM revealed two Incruse Ellipta multidose oral inhalers that had been used with no opened date recorded. The label on the inhaler instructed to discard 6 weeks after opening. An observation of the 300/400 hall medication carts on 11/13/23 at 12:00 PM revealed an opened bottle of Latanoprost ophthalmic drops with no opened date labeled on the bottle. The manufacturer's guidelines indicated to discard Latanoprost 6 weeks after opening. During an interview on 11/13/23 at 12:30 PM Nurse #9 stated she was the assigned nurse for the 300/400 hall medication cart. She stated expiration dates should be checked prior to administering the medications. She stated she was an agency nurse and had only worked in this building 3 or 4 times over the last year. She stated she arrived late for her shift and started out behind schedule. She stated she did not think to check for opened dates or expiration dates on the oral inhalers. She stated she should have	F 761	No specific residents were identified with the deficient practice. The multi dose oral inhalers and the ophthalmic drops were discarded and reordered on 11/15/23. An audit of all medication carts was performed by the Director of Nursing/designee on 12/12/23 to verify that all medications were dated appropriately when opened. No issues were identified. On 11/30/23-12/7/23 the Director of Nursing/designee provided reeducation to all licensed nurses on the medication storage policy and the expectation that when a medication is opened it must be dated with the appropriate date. Any licensed nurses that cannot be reached by our date of compliance will not take an assignment until they have received this reeducation by the Director of Nursing/designee. This includes any newly hired and new agency staff. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor all medication carts to ensure that opened medications are dated appropriately when opened. Monitoring will occur 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks then 1 x weekly for 4 weeks.	

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F 761	Continued From page 36 checked the medications. An observation of the 100-hall medication cart on 11/13/23 at 1:00 PM revealed 2 opened Advair Diskus multidose oral inhalers with no opened date recorded. The manufacturer's guidelines indicated to discard the inhaler 30 days after opening. During an interview on 11/13/23 at 1:30 PM Nurse #10 stated she was the assigned nurse for the 100 hall medication cart. She stated the nurse on the cart was expected to check for opened dates on medications. She stated the Infection Control nurse also did random checks of the medication carts at times. She stated no specific nurse was assigned to make sure medications were labeled with opened dates. She stated she did not always check for expiration dates on inhalers. During an interview on 11/13/23 at 4:00 PM the Corporate Nurse Consultant stated the oral inhalers and eye drops should have been labeled with opened dates once the medication was opened. He stated audits would be conducted of the medication carts and education provided to the nursing staff.	F 761	The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		12/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 37 §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, 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.	F 867		

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F 867	Continued From page 38 §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; 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	F 867		

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F 867	Continued From page 39 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; (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 7/6/21. This was for a deficiency originally cited in the area of Label/Store Drugs and Biologicals (F761). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Findings included:	F 867	The facility failed to maintain implemented procedures and monitoring interventions put in place following a recertification and complaint investigation survey completed on 7/6/2021. Revised plans have been developed to address those areas with ongoing monitoring by the Quality Assurance and Performance Improvement Committee (QAPI) for F761 Label/Store Drugs and Biologicals. All residents have the potential to be effected. On 12/12/23, A Root Cause Analysis was completed by the	

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F 867	Continued From page 40 This tag is cross-referenced to: F761: Based on observations, record review, and staff interviews the facility failed to record an opened date on multi dose oral inhalers and record an opened date on ophthalmic drops on 3 of 3 medication carts reviewed for medication storage. During the recertification and complaint investigation survey of 7/6/21 the facility failed to discard two opened and accessed bottles of eye drops per the pharmacy label on the box and failed to store an opened and accessed bottle of liquid nebulizer medication in the refrigerator as directed by the pharmacy label for 1 of 2 medication carts observed. The facility also failed to label and place an opened date on an open and accessed bottle of liquid nebulizer medication in the medication room refrigerator for 1 of 1 medication storage rooms observed. In an interview with the Administrator on 11/16/23 at 2:58 PM he stated he did not know why the plan failed. He noted he was new to the building and would be gathering information regarding the survey conducted in 2021 to determine strategies to improve the new plan of correction that will be implemented.	F 867	interdisciplinary Quality Assurance Team for this deficient practice to determine the systemic break with revised plans developed to address these areas. Education was provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Corporate Nurse Consultant on 12/11/23 regarding Quality Assurance and recognizing areas for Performance Improvement and how to report these findings to the QAPI Committee. The Administrator will conduct a Quality Assurance and Performance Improvement Meeting weekly x4 weeks (starting 12/11/23), bi-weekly x2 weeks, then monthly x1 month. The QAPI Committee will review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine the Root Cause Analysis of non-compliance with revisions to the plan as indicated. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.	