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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/24/23 through 11/02/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8P2511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/24/23 through 11/02/23. Event ID# 8P2511. The following intakes were investigated NC00208720, NC00208981, NC00208987, NC00209097, NC00209255, NC00209313, and NC00209345. Five (5) of the ten (10) complaint allegations resulted in deficiency.	F 000		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in physical or mental status was identified for 1 of 1 resident with a PASRR Level II determination reviewed for PASRR (Resident #11). The findings included:	F 646	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.	11/22/23

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

Electronically Signed | 11/20/2023

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

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F 646	Continued From page 1 Resident #11 was admitted to the facility on 11/6/18. Her cumulative diagnoses included post-traumatic stress disorder (PTSD), bipolar disorder, depression, and anxiety disorder. The resident's electronic medical record (EMR) included information from the North Carolina Medicaid Uniform Screening Tool (NC MUST). This record revealed Resident #11 was evaluated and found to have a PASRR Level II determination with a start date of 4/4/19. The PASRR Level II evaluation assessed the resident for the appropriateness of nursing facility placement and her potential need for specialized care. The Level II designation specified there was no end date and no limitation unless the resident had a change in condition. A review of Resident #11's EMR revealed the resident experienced a fall on 8/2/23 with a right bimalleolar ankle fracture (a type of ankle fracture that involved both the tibia and fibula, the lower leg bones that end on either side of the ankle). She was hospitalized for repair of the fracture with return to the facility on 8/7/23. The resident's most recent Minimum Data Set (MDS) was a significant change assessment dated 8/16/23. The MDS reported that Resident #11 was a PASRR Level II resident. An interview was conducted on 10/26/23 at 10:30 AM with the facility's Director of Discharge Planning and the Regional Discharge Planner. An inquiry was made as to whether a referral was made to the state mental health authority for evaluation of Resident #11 after she had a significant change in condition. At that time, the Regional Discharge Planner reported a referral	F 646	F646 1. Resident #11 Preadmission Screening and Resident Review Screening was submitted to North Carolina Department of Health and Human Services on 10/29/2023. 2. The Social Worker reviewed current residents with a significant change for the following dates 7/31/2023 through 11/7/2023 and submitted PASRR screening to NCDHHS. Completed 11/7/2023 3. On 10/29/2023 the Director of Nursing educated the Director of Social Services and the Assistant of Social Services on the following: a nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. The Director of Social Services will ensure that individuals with a mental disorder or intellectual disabilities continue to receive the care and services they need in the most appropriate setting when a significant change in their status occurs. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Administrator will review residents with a significant change to ensure the social worker submits a PASRR screening weekly for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of	

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F 646	Continued From page 2 hadn't been made because Resident #11's significant change was not related to her mental health. She stated that it would be the Discharge Planner's responsibility to request a re-evaluation, if needed. During a follow-up interview conducted on 10/26/23 at 10:47 AM, the Regional Discharge Planner stated she was not aware a referral for re-evaluation of a PASRR Level II needed to be made when a resident had a significant change in her physical condition.	F 646	weekly audits to ensure any issues identified are corrected. 5. Compliance date: 11/22/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews of the staff, Nurse Practitioner #2, facility Physician, and Pharmacist, the facility failed to determine or assess the need to continue daily bedside blood sugar monitoring for an insulin dependent resident with numerous comorbidities for 1 of 3 residents reviewed for diabetic blood glucose monitoring. Findings included: Resident #135 was admitted to a Long-Term Acute Care (LTAC) facility after a head injury on 6/19/23. A review of the resident's LTAC record	F 684	Past noncompliance: no plan of correction required.	

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revealed the head injury resulted in respiratory failure that required him to remain on ventilator life support for his first 4 weeks and was weaned off the ventilator. The resident had daily fasting blood glucose monitoring for diabetes.

The discharge summary from the LTAC dated 9/29/23 included orders in the discharge summary from the LTAC for medical staff to thoroughly and timely monitor the resident, for insulin glargine subcutaneous solution pen-injector 100 units/milliliter 35 units at bedtime, and for enteric feed 1.5 at 50 milliliter per hour continuous (gastrostomy tube feeding). Blood glucose monitoring was not documented in the LTAC discharge summary provided to the facility.

Blood glucose monitoring records from the LTAC for Resident #135 were obtained by the surveyor on 10/27/23 and documented the last five consecutive daily fasting blood glucose levels were as follows: 161, 210, 227, 152, and 254.

Resident #135 was admitted to the facility on 9/29/23 with the diagnosis of type 2 diabetes mellitus, head injury with bleeding and removal, encephalopathy, respiratory failure requiring ventilator support, and dysphagia with tube feeding.

On 10/27/23 at 3:30 pm an interview was conducted with Nurse #2. Nurse #2 stated she was the admitting nurse for Resident #135 on 9/29/23. She input the admission orders and informed NP #2 about the resident admission. Nurse #2 stated NP #2 reviewed and signed off on Resident #135's orders. An order for blood glucose monitoring was not in the LTAC

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discharge summary and was not added by NP #2. Nurse #2 further stated all admission orders were input by nursing and signed off by the Nurse Practitioner (NP) in the facility. Weekend resident admissions had an on-call NP sign off on orders. The NP was in the facility from 8:00 am to 5:00 pm Monday through Friday and the NP signed off on Resident #135's orders in the facility on day of admission, 9/29/23. Resident #135 had no order for daily blood glucose check and the NP would decide to add that order, not nursing. Nurse #2 indicated not all residents who had an order for long-acting insulin and stable blood glucose had a daily blood glucose check.

Resident #135 had physician orders dated 9/29/23 for insulin glargine subcutaneous solution pen-injector 100 units/milliliter 35 units at bedtime and enteric feed 1.5 at 50 ml per hour continuous (gastrostomy tube feeding). There were no orders for finger-stick or lab draw for blood glucose level on admission. The orders were entered by nursing staff and signed off by Nurse Practitioner (NP) #2.

The diabetic care plan dated 9/29/23 documented Resident #135 was at risk for diabetic complications and blood glucose fluctuations related to diabetes mellitus due to insulin administration. The interventions were to administer insulin and complete labs as ordered and to observe for signs of hyper and hypoglycemia. (There was no intervention for blood glucose monitoring.)

Resident #135 had an order initiated on 9/30/23 by the facility Physician for chemistry lab (including blood glucose) and hemoglobin A1C (measures the average blood glucose level for

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the past 2 to 3 months) to be drawn on 10/2/23 and 10/3/23.

On 10/27/23 at 4:40 pm an interview was conducted with the consultant pharmacist that completed the resident's admission medication review, Pharmacist #1. He stated he reviewed Resident #135's admission medication on 9/29/23 at 9:06 pm electronically. There were no irregularities at that time. The check was for appropriate medication by diagnosis and dosage with any contraindications in mind. There would be no specific history at that time and the monthly pharmacy review and admitting physician would be responsible for history review. He also stated that a pharmacist would not make blood glucose monitoring recommendations, and this was the responsibility of the medical staff.

Resident #135's non-fasting blood glucose laboratory results ordered for 10/2/23 was 286. On 10/27/23 an interview was conducted with Nurse #3. Nurse #3 stated blood sugars were not fasting, the tube feeding was not shut off for Resident #135's two lab draws.

Resident #135 was seen by the facility Physician on 10/2/23 for a history and physical which documented the resident was admitted from a long-term acute care (LTAC) facility where he had been since 6/19/23 from persistent encephalopathy following traumatic brain injury with subdural hematoma (blood collection in the brain) and subsequent surgical evacuation. The resident had respiratory failure during the LTAC admission and was hospitalized before being admitted to the facility. The resident had hemiparesis and required assistance with all activities of daily living, uncomplicated diabetes

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mellitus type 2, and dysphagia which required gastrostomy tube feed for nutrition. The resident's cognitive baseline was unknown due to a lack of records and family input. The plan was to check baseline labs and to contact the resident's family about his prior level of function. The lab report dated 10/2/23 comprehensive metabolic panel blood glucose was 286 (normal range 70 - 99) and hemoglobin A1C 8.8 (normal range below 5.9).

A review of Resident #135's physician orders revealed no new orders from the facility Physician from his 10/2/23 visit.

Resident #135 was seen by the Nurse Practitioner (NP) #2 on 10/2/23 for a history and physical. The NP documented she reviewed the LTAC record. The resident was a 94-year-old who was admitted from the LTAC where he had been since 6/19/23 for persistent encephalopathy following traumatic brain injury with subdural hematoma (SDH) and subsequent surgical evacuation, hemiparesis, diabetes, chronic hypoxic respiratory failure, and tracheostomy dependent eventually decannulated at the LTAC. The resident had dysphagia which required gastrostomy tube feed for nutrition and medication. His cognitive baseline was uncertain. The resident was discharged to the facility for debility. The resident had no apparent needs at this time. The resident was resting comfortably in bed with no acute distress.

Resident #135's non-fasting blood glucose laboratory result ordered for 10/3/23 was 151. On 10/27/23 at 5:40 pm an interview was conducted with Nurse #4. Nurse #4 stated she was assigned to Resident #135 on 10/5/23 7:00

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pm to 7:00 am shift. Nurse #4 stated she completed the shift assessment at approximately 3:30 am while the resident was awake. The resident had stable vital signs (within his usual range) including oxygen level. The resident had no distress and was breathing easily. He had no concerns, was able to follow simple commands, and made eye contact.

Resident #135's nurses note dated 10/6/23 at 12:43 pm written by Nurse #3 documented the resident was found to have an altered mental status with little to no communication. The resident had his eyes open but no verbal response and could not follow with his eyes. The resident's blood pressure was 106/64, pulse 56 and thready, respirations 24 with periods of apnea, and oxygen saturation was 94% on 2 liters of oxygen by nasal cannula. The NP #2? evaluated the resident and gave orders to transfer him to the hospital via emergency medical services.

On 10/27/23 at 8:10 am an interview was conducted with Nurse #3. Nuse #3 stated that she assessed Resident #135 at about 10:00 am on 10/6/23 and he was at his baseline. He could respond to simple questions and made good eye contact. Around 12:00 pm the resident was found to be staring off and unable to respond or make eye contact as usual. The NP was notified, and the NP ordered a current set of vital signs. The resident's respiratory rate was up to 24 and the pulse was 54, which was lower than earlier in the morning. The resident was afebrile. The NP ordered for immediate transfer to the hospital. Emergency services were contacted by using 911. Nurse #3 stated the NP informed her the resident may have had an infection and had not

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ordered a blood glucose check. Nurse #3 stated she followed the NP's order and had not considered checking a blood glucose level at that time.

A review of Resident #135's change in status form 10/6/23 completed by Nurse #5 documented a change in the resident's mental status. At the time of evaluation, the resident's vital signs were as follows: Blood Pressure: 106/64 11:11 am, Pulse: 54 - 12:35 pm, Respiratory rate: 18 at 11:12 am (24 at 1:00 pm); Temperature: 97.0 at 11:12 am route: forehead (non-contact); Pulse Oximetry: 94.0 % - 11:12 am method: room air, and Blood Glucose: was left blank. The Primary Care Provider responded and ordered Resident #135 to be sent to the Emergency Department for further evaluation.

On 10/25/23 at 11:40 am an interview was conducted with Nurse #5. Nurse #5 stated she was familiar with Resident #135 and had checked his vital signs the morning of 10/6/23 as ordered by the NP and informed the NP of the resident's change of altered mental status. Nurse #5 stated she completed the change in assessment form. The resident was sent out immediately to the hospital for suspected infection. The interview further revealed the NP had not requested Nurse #5 to complete a blood glucose check when she obtained Resident #135's vital signs. Nurse #3 obtained additional vital signs at 12:00 pm with an increase in respiratory rate to 24.

A review of Resident #135's Emergency Medical Services (EMS) record dated 10/6/23 at 1:08 pm documented the impression was sepsis/septicemia. The resident's vital signs were blood pressure 103/65, respiratory rate 61,

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pulse 68, oxygen saturation 98% on oxygen, blood glucose 551 (normal range 70 to 99), and temperature 101. The resident was not responding but alert. Intravenous fluids of lactated ringers 500 cubic centimeters (cc) and normal saline 250 ccs were administered enroute. At 1:23 pm, the resident's pulse increased to 129 enroute to the hospital.

A review of Resident #135's admission hospital record dated 10/6/23 documented the resident was seen in the Emergency Department for an altered mental status. The resident was found to have a blood glucose result of 868 and a positive COVID test and radiograph for COVID pneumonia. Urine and blood were obtained for culture to rule out sepsis. The resident was admitted to the hospital with COVID pneumonia and MRSA (methicillin resistant staph aureus) pneumonia (by culture). The record documented the diabetes type 2 diagnosis was hyperosmolar hyperglycemic state (HHS) [large amount of blood glucose] due to COVID and MRSA pneumonia sepsis. The resident received an insulin intravenous drip to normalize his blood glucose. The resident was found to have sepsis from pneumonia on day 2.

On 10/26/23 at 2:50 pm an interview was conducted with NP #2. The NP stated she remembered Resident #135. He was debilitated and had several comorbidities. The resident had an altered mental status on 10/6/23 reported by the nursing staff, and it was suspected that he had an infection and was transferred to the hospital immediately. The NP stated the resident had two labs for non-fasting blood glucose levels. The NP stated she had not known why there was not an order for daily fasting blood glucose for

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Resident #135, there should be a fasting blood glucose check for a resident that received insulin. The resident was stable and alert until the morning of 10/6/23 by nursing report and record review.

On 10/25/23 at 9:05 am an interview was conducted with facility Physician. The Physician stated he remembered Resident #135 and when he completed the resident's history and physical for admission, he noted there were no blood glucose monitoring records from the LTAC only a current list of diagnoses and medications. The Physician stated he was informed by the NP that the resident was sent to the Emergency Department (ED) on 10/6/23 after assessment and discussion with the family member that the resident had an altered mental status. The resident had encephalopathy, and he was hard of hearing. The ED record dated 10/6/23 documented the resident had a blood glucose of 868 and COVID infection with sepsis. The resident was 94 years old and had multiple comorbidities including encephalopathy. The physician stated that the resident had stable blood glucose determined by an unchanged long-acting insulin and was receiving tube feeding with known calories at the LTAC and facility that were the same. The insulin order and tube feed remained the same at both facilities for more than 4 months. There was no regular blood glucose check order at the facility. The resident had 2 bloods draws for chemistry, which included blood glucose level. The physician stated he would expect nursing to request a blood glucose order if needed in addition to the labs he ordered if the resident had any changes.

On 10/25/23 at 10:50 am an interview was

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conducted with the Director of Nursing (DON). The DON stated she remembered Resident #135. He was sent out to the Emergency Department for an altered mental status on 10/6/23. After the hyperglycemia result for Resident #135 at the hospital, an audit of all residents receiving diabetic medication, insulin or by mouth, was completed (current and new admits). Any resident that did not have an order for blood glucose check, an order was initiated. Only a few residents with stable diabetic blood glucose levels with oral or long-acting insulin needed an order. There were some oriented residents (about 2) that did not want to start having their blood glucose checked daily that were stable. The NP who signed off on resident orders upon admission was responsible to order blood glucose checks if needed. Nursing staff received education and the blood glucose audits for diabetic residents were ongoing.

The facility provided the following corrective action plan with a completion date of 10/16/23:

1. Corrective action for resident(s) affected by the alleged deficient practice:
Resident #135 no longer resided in the facility.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
The Director of Nursing and Unit Managers reviewed current residents with diabetic medication orders to ensure all residents were receiving blood sugar checks for (9/1/2023 - 10/9/2023) and new admissions to ensure accuracy of orders, completed 10/12/2023. The Director of Nursing reviewed current residents with the medical diagnosis of diabetes to ensure

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residents had an order to obtain blood sugar. Residents without an order to obtain blood sugar were discussed with the Medical Director and new orders were obtained, completed 10/12/2023. The Director of Nursing reviewed current residents' blood sugar to ensure any results <60 and/or >400 were reported to the facility physician, completed 10/11/2023. The Director of Nursing reviewed current residents with the medical diagnosis of diabetes to ensure hemoglobin A1C levels (blood glucose level over a period) were obtained as ordered. If an A1C level was not obtained, it was discussed with the facility physician and obtained new orders, completed 10/12/2023.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
The Director of Nursing educated the Unit Managers regarding the process for verifying new admission orders for residents admitted to the facility. The staff development coordinator educated the licensed nurses when a resident has an order for insulin, they were to ensure residents had an order to obtain blood sugars, when a resident had a change in condition the nurse was to obtain vital signs, and this was to include blood sugar level. The staff development coordinator educated licensed nurses on signs and symptoms of hypoglycemia and hyperglycemia. Newly hired licensed nurses will receive this education in orientation. The RDCS (Regional Director of Clinical Services) educated the Director of Nursing and Nurse Managers regarding the validation of new admission orders during the morning clinical meeting for admissions from the prior day. Completed 10/16/23.

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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 Director of Nursing and designee will review new admission orders on the next business day for accuracy daily x 8 weeks. The Director of Nursing will review 4 residents on each unit (4) who received diabetic medication to ensure residents were receiving blood sugar checks as ordered by the facility physician weekly x 8 weeks. Results of these audits will be reviewed at the Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified were corrected. Ongoing.
QAPI (Quality Assurance/Performance Improvement) meeting was held on 10/18/2023 and the blood glucose monitoring process was discussed, and the process was determined to be working.

Compliance Date: 10/16/2023

Validation of the corrective action plan was completed on 10/27/23:

Documented roster for education of licensed nursing, Unit Managers, and DON were reviewed.

Audits completed of all residents that received insulin were reviewed and daily blood glucose orders were added for four residents. There was one new resident admission that had an order for blood glucose daily testing documented.

Nursing staff and the DON were interviewed on 10/27/23 for education received and ability to

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F 684	Continued From page 14 state the new blood glucose monitoring process and signs and symptoms to report. Nurses worked 12-hour shifts. Four nurses on day shift and 2 on night shift were interviewed for education received by the Director of Nursing: residents that had an order for insulin were to have an order to obtain daily blood sugars, when a resident had a change in condition the nurse was to obtain vital signs, and this was to include blood sugar level and report to medical staff. Nursing staff were able to state the Staff Development Coordinator educated licensed nurses on signs and symptoms of hypoglycemia and hyperglycemia and actions to take. Newly hired licensed nurses will receive this education in orientation. The completion date of 10/16/23 was validated.	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner (NP) and Medical Director's interviews, the facility failed to prevent a significant medication error by failing to administer prescribed extra dose of diuretic medication to a resident resulting in two doses of medication being missed for 1 of 1 resident (Resident #128) reviewed for medication errors. Findings included: Resident #128 was admitted on 8/9/23 with	F 760	F760 1. Resident #128 received Lasix 10/28/2023 □ 10/30/2023. 2. The Director of nursing reviewed current residents□ new orders from 10/23/2023 □ 11/17/2023 to ensure the orders were confirmed timely and given according to the prescribing practitioner. The other orders were confirmed and completed as ordered. Completed 11/17/2023 3. The Unit managers received	11/17/23

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F 760	Continued From page 15 diagnoses that included congestive heart failure, and Peripheral vascular disease (PVD). Review of the physician order dated 8/10/23 read in part "Furosemide oral tablet 20 milligrams (MG) (Furosemide)- Give 1 tablet by mouth one time a day". Review of the admission MDS dated 8/15/23 revealed the resident was assessed as moderately cognitively impaired. Assessment indicated the resident received diuretics for 6 of 7 days during the look back period. Review of the care plan dated 8/24/23 revealed the resident was care planned for use of diuretic and at risk for complications secondary to diuretic use due to diagnosis of congestive heart failure. The goal indicated that the resident will not have any complications related to diuretic use. Interventions included administration of medications as ordered, auscultating (listening to) lung sounds as needed, labs as ordered; observing for edema and notifying physician (MD) as indicated. Staff to observe for signs and symptoms of fluid imbalance including dehydration or fluid overload and notifying MD as needed. Review of the NP note 10/17/23 read in part "wound care nurse requested an acute visit due to the patient having bilateral lower extremity swelling with left leg weeping. On examination, the patient has about +1-2 pitting edema in the lower extremities L>R (left greater than right). The patient has a history of CHF (congestive heart failure) and is on 20 mg of furosemide daily. Will increase to 40 mg x3 days.". Note indicated Resident #128 had a history of PVD.	F 760	education from the Director of Nursing on 11/17/2023 regarding reviewing the pending orders on business days. Unit managers received education by the Director of Nursing on 11/17/2023 when they are on-call they are to review the pending confirmation orders to ensure they are confirmed and given according to the prescribing practitioner. If orders are not confirmed or given according to the prescribing practitioner a medication error is to be filled out, the prescribing practitioner will be called and given to the Director of Nursing for review with the medical director. Effective 11/17/2023 the Staff development coordinator will educate the license nurses on reviewing the pending orders during their shift and implement according to prescribing physician. Effective 11/17/2023 the Staff development coordinator will educate the medication aides on if an order is seen pending, they are to inform the licensed nurse that is covering them immediately. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing will review the pending orders on random days to include weekends to ensure they are confirmed and given according to the prescribing practitioner 3 times weekly for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. 5. Compliant Date 11/17/2023	

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Review of the Wound NP note dated 10/18/23 indicated the resident was assessed for a follow up and an assessment of new left leg abrasion. Resident with significant increased bilateral lower extremities (BLE) edema. Note also indicated the NP was notified of increased BLE edema with recommendations for additional diuretic.

Review of the physician order dated 10/18/23 read in part "Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for 3 days."

Review of the Medication administration record for October 2023 revealed the physician order "Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for Edema for 3 Days was marked as administered on 10/18/23, 10/19/23 and 10/20/23. Medication administration record also indicated the physician's order "Furosemide Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day" was on hold for these three days and was not administered.

Nursing note date 10/23/23 revealed the resident was noted to have +2 pitting edema to bilateral legs. The NP has assessed the resident and noted that the resident was already on Lasix 20 mg daily. NP did not want to increase the Lasix due to the weight of the resident.

Review of the NP note dated 10/23/23 read in part "Nursing requested an acute visit due to patient's lower extremity being edematous. The patient has edema in bilateral lower extremity, it is worse in bilateral feet about +2 pitting edema. The patient's Lasix was increased for 3 days last

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week. Edema has improved today; however, patient has redness on both extremities and are painful." Note indicated the resident had a history of PVD.

Review of the wound NP note dated 10/24/23 revealed the resident was seen on 10/24/23 for a follow-up and an assessment of left leg abrasion. Medication review revealed the resident currently on Furosemide oral tablet 20 MG one time a day. Note read in part "Recommendations LLE may have delayed wound healing due to history of PVD and current BLE edema." Note also indicated the NP was notified of BLE edema and recommendation for addition Lasix (diuretic) if tolerated by the resident.

Nursing note dated 10/25/23 read in part "Wound care provider recommends additional Lasix. This writer made provider (NP name) aware of recommendation. Provider states she will review resident's meds and follow-up."

Review of the physician order dated 10/26/23 revealed Furosemide Oral Tablet 20 MG (Furosemide), 1 tablet by mouth one time a day for Edema for 2 Days.

Review of the Medication administration record for October 2023 revealed the physician order "Furosemide oral tablet 20 MG (Furosemide), Give 1 tablet by mouth one time a day for Edema for 2 Days. Order date10/25/2023 and discontinue date10/28/2023 was not marked as administered.

During an interview on 11/02/23 at 11:46 AM Med Aide#1 stated she was assigned to the resident on 10/26/23. Resident #128 received Lasix 20 mg

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daily. Med Aide#1 stated the resident returned from a medical appointment that day and there was a pending order for Furosemide oral tablet 20 MG for the resident. Med Aide further stated had notified the nurse (name unknown) about the pending order. Medication was not administered as it was in pending status. Med Aide #1 indicated any medication that was on pending confirmation status could be seen on the Medication Administration screen as pending confirmation and cannot be checked off. The medication needed to be confirmed by a Nurse before it can be administered to the resident.

During an interview on 11/02/23 at 3:53 PM, Med Aide#2 stated she was assigned to the resident on 10/27/23. Med Aide #2 stated the resident had a pending order for medication. She indicated she does not recollect the name of the medication. Med Aide #2 further indicated that she reported to the nurse (name unknown) regarding the pending order. Med Aide #2 stated she had not administered the medication as it was on pending confirmation status.

During an interview on 11/02/23 at 12:01 PM, Nurse #2 stated she was assigned to the resident on 10/26/23 and 10/27/23. Nurse #2 stated the Med Aide's were managing the medication carts and does not recollect being notified of any pending orders. Nurse #2 indicated she usually checks for any pending confirmation 2-3 times during her 12-hour shift and does not recall the resident having any pending orders for diuretics. Nurse stated when any order was in que for pending confirmation, the nurse had to confirm the order so that it could be active and administered to the resident. She confirmed that Med Aides could not confirm medication orders.

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She added there was no report given regarding any pending confirmation on those days.

During an interview on 11/02/23 10:03 AM, Nurse #5 stated she was the unit manager to a different hallway and was assisting in the hallway the resident resided on 10/25/23. Nurse #5 indicated she reviewed the resident's wound report on 10/25/23 and notified the NP that the wound care provider recommended additional dosage of Lasix. Nurse #5 further stated the NP had indicated to her that she would review the resident's medications and follow up. No new orders were given that day. Nurse indicated the resident was receiving Lasix 20 mg daily, and there was a recommendation for some additional doses. Nurse #5 stated when the order was placed by the physician or NP, the orders needed to be confirmed. The confirmed orders go directly to the pharmacy so that they can be filled and sent to the facility. Nurse #5 indicated she was unsure why the medication was not confirmed for 2 days. The NP was notified that the medication was confirmed late on 10/28/23 and the resident received the medication as ordered on 10/28/23.

During an interview on 11/2/23 at 9:09 AM, the Registered Nurse (RN) supervisor stated on 10/24/23 the Wound NP recommended an extra dose of Lasix if tolerated by the resident for 2 days. The RN supervisor stated she communicated this with the facility NP. The NP did not want to add additional dose of medication as the resident was already on Lasix and the resident's edema had reduced considerably. The Unit Manager (Nurse #5) assisting the hallway also notified the NP regarding the Wound NP note on 10/25/23. The NP had informed her that she would like to review the resident before any

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medication was added. The RN supervisor indicated the NP had placed the order for Lasix on 10/25/23 at 10:36 PM. However, this order was to be verified by the nurse before it becomes active. The medication was not confirmed on 10/26/23. The Weekend supervisor was auditing the new orders when she realized that the orders were not confirmed. The Weekend supervisor called the nurse practitioner, and a new order was received on 10/28/23 for an extra 2 doses of Lasix. The RN supervisor stated the medication would have been displayed as pending confirmation on Medication Administration system for the morning staff as it was scheduled as an evening dose.

During a telephone interview (on 11/2/23 at 12:40 PM, the Wound NP stated on 10/18/23 the resident had developed a new abrasion on her left lower leg. Wound NP further stated the resident does have some edema, however noticed had pitting edema more than usual. Wound NP stated a small dose of Lasix was added for few days and the edema had improved. The wound NP stated during her assessment on 10/24/23 she noticed the resident's legs to be a bit puffier and the wound was getting bigger. She indicated she had recommended the extra dose of Lasix to help decrease reduce the edema to the lower legs. The wound NP stated the resident's wounds have improved during the recent assessment on 10/31/23. She added the resident's leg swelling had gone down a good amount. The Wound NP stated the resident had peripheral vascular disease, and compressions could not be worn, hence recommended for leg elevation. The Wound NP stated she was not sure how delaying Lasix would impact the resident's over healing, but overall the edema to

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her lower extremities had reduced.

During an interview on 11/02/23 at 10:42 AM, NP stated the resident had multiple medical conditions including PVD, resulting in pain, edema, and coldness in her feet. NP indicated the resident was on regular 20 mg of Lasix daily and her edema was mild. The medication was increased if the edema increased and was increased just for 2-3 days, nothing longer. The NP indicated the resident has a wound on her left leg, and when edema increased, it caused weeping through the skin especially to her left leg. The NP stated the resident was followed by a Wound NP for her surgical breast wound and abrasion on her legs. The Wound NP had recommended some extra dose of Lasix for the resident. The NP stated she entered the order per wound recommendations. The resident had mild edema during the previous assessment, however order was placed just to cover the recommendation. NP further stated she was made aware on 10/28/23 of the order not confirmed. The nurse informed her the resident had very mild edema, hence a new order to start only for 2 days was given. The medication was not critical, as she was already on a daily dose and could wait till 10/30/23 to even get the medication. This was a low dose of Lasix for just 2 days.

During a telephone interview on 11/2/23 at 12:32, the Medical Director stated the resident had vascular disease and was on a daily low dose of Lasix. The Medical Director stated he was unsure why the wound team had recommended additional doses. He indicated the NP was made aware of this recommendation and after complete review of the resident, the NP agreed to order 2

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F 760	Continued From page 22 doses of 20 mg of Lasix. The Medical Director stated for reasons unknown the medication order was not noticed or validated immediately. The order was confirmed 2 days later. The order was for 2 extra doses of Lasix 20 mg. The Medical Director stated missing this low dose of Lasix while the resident received their regular dose would not medically impact the resident. The resident had Peripheral vascular disease and the Lasix administered was used to reduce some of her edema. The Lasix was not ordered for any active heart failure and missing a dose or two or receiving the medication late would not cause any negative or significant impact on the resident's medical condition. During an interview on 11/02/23 11:50 AM, the Director of Nursing (DON) stated the orders were placed in the system late at night. The nurse assigned to the resident should have confirmed the orders. The DON indicated nurses had to check the medication administration system to confirm any new orders as there was no alert system notifying them of new order confirmation. DON stated the NP was immediately notified about the orders been missed for 2 days and new orders were placed. The resident was already on daily dose of Lasix.	F 760		
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.	F 761		11/22/23

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F 761	Continued From page 23 §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, interviews with staff, and record reviews, the facility failed to: 1) Accurately label medications (meds) to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Teal Middle Med Cart, Mauve 1 South Med Cart, and Mauve 2 North Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 2) Discard expired medications and/or meds without a legible expiration date on 1 of 4 medication carts (Teal Middle Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 3) Label medications with the minimum information required, including the name of the resident, on 1 of 4 medication carts (Mauve 2 North Med Cart) observed; 4) Store medications in accordance with the manufacturer's storage instructions on 1 of 4 medication carts (Mauve 1 South Med Cart) observed.	F 761	F761 1. The medication cetirizine bottle, Novolin 70/30 insulin vial, Humalog insulin vial, Ipratropium/albuterol inhalation foil pouch, Toujeo insulin pen, Acetylcysteine solution vial, and a Levemir insulin pen were discarded on 10/25/2023. 2. The Director of Nursing and unit managers reviewed the medication carts and the medication rooms to ensure medications were label appropriately and if any medication were expired or not label the medication was discarded. Completed on 11/17/2023 3. Effective 11/17/2023, the staff development coordinator and designee educated the license nurses and medication aides on when a medication such as a multi-dose vial, insulin pens,	

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F 761	Continued From page 24 The findings included: 1-a. An observation was 10/25/23 at 10:38 AM of the Teal Middle Medication (Med) Cart in the presence of Med Aide #3. The observation revealed a stock bottle of 10 milligram (mg) cetirizine (an over-the-counter antihistamine) with approximately 45 tablets remaining in the bottle was stored on the med cart. The manufacturer's expiration date on the stock bottle of cetirizine was not legible. When the med aide was asked what the expiration date on the bottle read, she stated, "I can't see it." At that time, Nurse #12 approached the med cart and attempted to read the expiration date on the stock bottle of cetirizine. Nurse #12 stated they would need to pull the stock bottle off the med cart because she would not know what the expiration date of the medication was. 1-b. An observation was 10/25/23 at 10:38 AM of the Teal Middle Med Cart in the presence of Med Aide #3. The observation revealed an opened 10 milliliter (ml) vial of Novolin 70/30 insulin dispensed for Resident #47 was stored inside of a plastic medication vial on the med cart. Both the plastic medication vial and the insulin vial itself were labeled only with the resident's name and room number. The insulin vial was not dated as to when it had been opened to allow for a determination of its shortened expiration date. When asked, Med Aide #3 confirmed the insulin was not labeled to indicate when it had been opened. According to the product manufacturer, opened (in-use) vials of Novolin 70/30 insulin should be stored at room temperature and used within 42	F 761	and breathing treatments are to be dated according to the manufacturer's instructions. Education will continue in orientation with new hire. In-person and/or via phone. The facility does not currently use agency. 4. The Director of Nursing and unit managers will review all medication rooms and medication carts 3 times weekly for 12 weeks to ensure medications are dated according to the manufacturer's instructions. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date 11/22/2023 5. Compliance Date 11/22/2023	

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	345420	A. BUILDING _____ B. WING _____	C 11/02/2023

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days.

An interview was conducted on 10/25/23 at 3:12 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor stated when the nursing staff checked the medication carts, any medication without a legible expiration date would need to be replaced. Upon further inquiry, she also reported insulin vials and pens should have both the "opened" date and "discard" date written on the medication.

2-a. An observation was 10/25/23 at 11:30 AM of the Mauve 1 South Med Cart in the presence of Nurse #11. The observation revealed an opened 10 milliliter (ml) vial of Humalog insulin dispensed for Resident #106 was stored inside of a plastic medication vial on the med cart. Tape was wrapped around the outer plastic medication vial with a handwritten notation, "open 8/5/23." However, a sticker which read "Beyond Use Date" was also placed on the vial with a handwritten date of "10/31/23" noted on this sticker. Upon review of these dates, Nurse #11 was observed as she removed the tape with the open date of 8/5/23. When asked how she knew which date was correct, the nurse stated, "I'm going to go by the use-by date."

According to the product manufacturer, once punctured (in use), vials of Humalog insulin may be stored in the refrigerator or at room temperature and should be used within 28 days.

2-b. An observation was conducted on 10/25/23 at 11:30 AM of the Mauve 1 South Med Cart in the presence of Nurse #11. The observation revealed four (4) vials of 0.5 milligram (mg) / 3 mg per 3 milliliters (ml) of ipratropium / albuterol

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inhalation solution (an inhaled medication delivered via a nebulizer to treat asthma or chronic obstructive lung disease) dispensed for Resident #39 were observed to be lying in the manufacturer's box outside of a foil pouch. No date was written on the vials as to when they had been removed from the foil pouch.

The manufacturer's storage instructions for the ipratropium / albuterol inhalation solution instructed that unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week.

An interview was conducted on 10/25/23 at 11:42 AM with Nurse #11. When asked, the nurse reported she was not aware the vials of ipratropium / albuterol inhalation solution had a shortened expiration date once they were removed from the foil pouch.

An interview was conducted on 10/25/23 at 3:12 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor reported insulin vials and pens should have both the "opened" date and "discard" date written on the medication. When asked, she also stated the individual vials of inhalation solution needed to stay in the foil pouch and the foil should be dated as to when it had been opened.

3-a. An observation was conducted on 10/25/23 at 2:35 PM of the Mauve 2 North Med Cart in the presence of Med Aide #2. The observation revealed an opened Toujeo insulin pen dispensed for Resident #40 was stored on the med cart with a handwritten Beyond Use Date of 9/22/23. However, another handwritten notation on a

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sticker placed on the insulin pen indicated its "Date Opened" was 10/9/23. When shown the two dates on the insulin pen, Med Aide #2 stated she was not sure which date was correct.

According to the product manufacturer, once punctured (in use), Toujeo insulin pens should be stored at room temperature and used within 56 days.

3-b. An observation was conducted on 10/25/23 at 2:35 PM of the Mauve 2 North Med Cart in the presence of Med Aide #2. The observation revealed a manufacturer's sample bottle of Gemtesa (a medication used to treat overactive bladder) with one tablet remaining in the bottle was not labeled with the minimum required information, including the resident's name.

An interview was conducted on 10/25/23 at 3:12 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor reported insulin vials and pens should have both the "opened" date and "discard" date written on the medication. Additionally, the RN Supervisor stated all prescription medications needed to be labeled with a resident's name.

4-a. An observation was conducted on 10/25/23 at 10:50 AM of the Mauve 1 Med Room in the presence of Nurse #5. The observation revealed a 30 milliliter (ml) vial of preservative-free acetylcysteine solution (a medication used to loosen and thin mucous) dispensed for Resident #113 was stored in the med room refrigerator. A sticker on the vial indicated it had been opened on "10/16/23." Manufacturer labeling on the medication vial read in bold print, "Discard opened containers after 96 hours." Upon review

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F 761	Continued From page 28 of the acetylcysteine vial, Nurse #5 reported the vial needed to be discarded. 4-b. An observation was conducted on 10/25/23 at 10:50 AM the Mauve 1 Med Room in the presence of Nurse #5. The observation revealed an opened, 10 milliliter (ml) vial of Levemir insulin dispensed for Resident #65 was not dated as to when it had been opened. Upon observation, Nurse #5 confirmed an opened date was not noted on the insulin vial. She stated, "We'll throw it out." According to the product manufacturer, once punctured (in use), vials of Levemir insulin may be stored under refrigeration or at room temperature and should be used within 42 days. An interview was conducted on 10/25/23 at 3:12 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor reported insulin vials and pens should have both the "opened" date and "discard" date written on the medication. When asked, she also stated the acetylcysteine solution should have been discarded within 96 hours after opening in accordance with the manufacturer's instructions.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		11/22/23

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F 812	Continued From page 29 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to label opened foods and maintain clean nourishment refrigerators for 3 of 3 nourishment refrigerators. The facility failed to maintain the outside of the ice machines, ice scoop and holder clean in 2 of the 3 nourishment rooms (Teal and Mauve #1). These practices had the potential to affect food being served to residents. Findings included: 1 a. During an observation on 10/24/23 at 9:25 AM, the nourishment refrigerator #1 on Teal hallway contained a takeout disposable container with food, a white disposable 16-ounce takeout cup with brown colored liquid, an opened soda can, 20 fluid ounce soda bottle that were not labeled. During an interview on 10/24/23 at 9:27 AM, the dietary manager stated all resident's food that was brought in by their family should be labeled with resident's name and date before it was placed in the refrigerator. The dietary manager further stated the food in the refrigerator did not belong to the residents and maybe staff's	F 812	F812 1. The food items that were identified with no label were discarded immediately upon notification on 10/24/2023. The nourishment refrigerators were cleaned on 10/25/2023 by the housekeeper. The ice machines, ice scoops, and holder were cleaned on 10/24/2023. 2. On 11/16/2023 the Infection Preventionist inspected the nourishment refrigerators to ensure the food items are labeled and dated appropriately. On 11/16/2023 the Infection Preventionist ensured the nourishment refrigerators were cleaned. On 11/16/2023 the Infection Preventionist ensured the ice machines, ice scoops, and holders were cleaned. 3. Effective 11/17/2023 the staff development coordinator will educate the current staff on ensuring when food items are placed in the nourishment refrigerators they are to be labeled and dated the date the food is received and to remain in the refrigerator no longer than 72 hours. Effective 11/17/2023 the staff	

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F 812	Continued From page 30 personal food. The dietary manager indicated she was responsible to ensure that all foods were labeled in these refrigerators and any unlabeled foods or drinks were thrown out during her morning checks. She further indicated staff should not be placing their personal food in the nourishment refrigerators. 1b. During an observation on 10/24/23 at 9:30 AM, the nourishment refrigerator #2 on Mauve 1 hallway contained an opened 36-ounce bottle with orange colored liquid labeled "Orange Juice" with no open date. An opened 64-ounces bottle containing reddish colored liquid labeled " cranberry juice" with no open date. The shelves of the refrigerator contained light brownish/ yellowish stains. The freezer contained an opened 16-ounce soda bottle what was frozen, an opened 16- ounce water bottle with yellow colored fluid and two 16 -ounce water bottles that were frozen. There were no labels on them. During an interview on 10/24/23 at 9:32 AM, the dietary manager stated the orange juice bottle and cranberry juice bottles should be labeled with an open date. The yellow-colored frozen fluid was water with yellow colored mix in it. The bottles in the freezer must be staff's personal drinks. 1c. During an observation on 10/24/23 at 9:35 AM, the nourishment refrigerator #3 on Mauve 2 hallway revealed yellow-colored stains on the shelves, and yellow colored liquid on the refrigerator floor and drawers. The freezer contained 2 plastic cups containing fruit covered with wax paper with no label on them, a 8-ounce soda can that was frozen and busted open, two 4-ounce cups with nectar thick liquid and a 4-ounce cup of applesauce that was frozen and	F 812	development coordinator educated current staff on if the refrigerators, ice machine, and ice containers with scoops are noted to be soiled they are to notify the unit manager of that unit or the director of nursing. Education will continue in orientation with new hire. In-person and/or via phone. 4. The infection preventionist will inspect the nourishment rooms to ensure the refrigerators, ice machines, and ice holders along with the scoops are cleaned 3 times a week for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. 5. Compliance Date: 11/22/2023	

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had no label on them. The freezer also contained a takeout fast food restaurant milk shake Styrofoam cup and 2 crush ice cream bars with no label. The floor of the freezer had dark brown colored stains.

During an interview on 10/24/23 at 9:40 AM, the dietary manager stated the housekeeping staff were responsible for cleaning the nourishment refrigerators. She stated the food in the refrigerators and freezers should be labeled with resident's name if it belonged to the resident. Sodas should not be placed in the freezer and staff should not place personal food in residents' nourishment refrigerator.

2a. Observation of the ice machine in the nourishment room #1 on Teal hallway on 10/24/23 at 9:25 AM, revealed brown colored stains on the outside of the ice machine. The ice scoop and the ice scoop holder had dust and light brown stains inside the holder.

The dietary manager stated the house keeping staff were responsible to clean the outside of the ice machine. She further stated the infection preventionist brought the ice scoops and holders to the kitchen to be washed. She was unsure why these scoop and holders were not sent to the kitchen to run through the dishwasher.

2b. Observation of the ice machine in the nourishment room #2 on Mauve1 hallway revealed the machine contained brown and black stains on the outside of the machine.

The dietary manager indicated the machines should be cleaned by housekeeping staff on the outside.

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During an interview on 10/27/23 at 10:24 AM, Housekeeping staff #1 stated she does not clean the nourishment refrigerator or ice machine. She stated she only cleans the floors and counter tops in the nourishment room.

During an interview on 10/27/23 at 10:30 AM, Housekeeping staff #2 stated she cleans the nourishment refrigerator as needed. She stated she checks the refrigerator to see if it needs cleaning and cleans the refrigerator if needed. She indicated there was no cleaning schedule. She further stated she does not clean the ice machine outside or inside. She indicated the housekeeping staff were not supposed to clean the ice machine.

During an interview on 10/27/23 at 10:45 AM, the Housekeeping Manager stated the nourishment refrigerators were cleaned twice a week and the outside of the ice machine was cleaned with "Microkill" EPA approved disinfected product. She stated she was responsible for ensuring the nourishment refrigerators were clean. The Housekeeping Manager indicated Housekeeping staff #1 should be clean the nourishment refrigerators and in her absence the Housekeeping staff #2 should be clean the nourishment refrigerator. As for the outside of the ice machine, the EPA approved disinfectant was sprayed and wiped off after 5 minutes of spraying the disinfectant.

During an interview on 10/27/23 11:06 AM, the infection preventionist stated he was responsible for taking the ice scoop and scoop holder to the kitchen for cleaning. He stated during the week he removes all scoops and scoop holder boxes

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F 812	Continued From page 33 early during the morning, take it to the kitchen where it was washed and dried. It was later placed back in the nourishment rooms. He indicated he was not available over weekend and thinks it was the housekeeping staff who were responsible over the weekends. During an interview on 10/27/23 at 12:33 PM, the Director of Nursing (DON) stated all nourishment refrigerators should be maintained clean. The refrigerators should be cleaned as scheduled and as needed. The ice machine should be cleaned regularly. Employees / staff should not place their personal food in the nourishment refrigerator. The nourishment refrigerator was for resident's food only. The DON further stated all resident's food brought by family should be labeled with resident's name and date. Any opened containers like juice bottles, med pass should be labeled with open date. The nourishment refrigerator should be checked to ensure all foods were labeled and expired food discarded appropriately. The DON stated the ice scoops and holders should be washed daily, even on the weekends.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		11/22/23

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 35 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on review of photographs of facility resident records and anonymous caller interview, the facility failed to protect the private health information for 3 of 4 sampled residents(Resident #119, #128 and #335) by staff photographing confidential medical information. In addition, based on record review and interview of staff, the facility failed to document the resident's insulin administration on the medication administration record for 9/29/23 at bedtime (Resident #135) for 1 of 3 residents reviewed for residents with diabetes. The findings included: 1a. Resident #119 was admitted to the facility on 9/28/22. b. Resident #128 was admitted to the facility on 8/9/23. c. Resident #335 was admitted to the facility on 10/20/23. An interview was conducted on 11/1/23 at	F 842	F842 1. On 11/17/2023 the residents□ #119 and #128 are their own Responsible Party and they were informed regarding the photographs of their confidential medical records. On 11/17/2023 the Responsible Party was called and informed of the photographs that were taken of the confidential medical records. Resident #135 no longer resides in the facility. 2. All current residents have the potential to be affected by deficiency practice. 3. Effective 11/17/2023 the staff development coordinator and designee educated current staff on protected health information is not to be photographed, recorded, emailed, text, nor have online postings, only with a few exceptions. Protected Health Information can only be disclosed for the purposes of treatment, payment, or healthcare operations. Any other disclosure can lead to a Health	

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F 842	Continued From page 36 2:36PM, the anonymous caller stated photographs of resident confidential medical information had been taken from the facility records. The photographs included medication administration orders taken from the order pending confirmation tab for Resident #119, #128 and #335. On 10/19/23, the state agency received copies of the photographs from a person in the community that was not employed by the nursing home. An interview was conducted on 11/2/23 at 10:00 AM, the Nurse Supervisor stated all nursing staff are responsible for completing the monthly electronic HIPPA training. Staff should not photograph any resident medical record information. An interview was conducted on 11/2/23 at 11:30 AM, the Acting Director of Nursing (DON) stated all employees were required to follow the facility HIPPA policy and protect resident confidential information. Staff should not photograph any part of the record. An interview was conducted on 11/2/23 at 12:15 PM, the Administrator stated all employees were expected to protect the resident medical record by following the facility HIPPA guidelines. 2. Resident #135 was admitted to the facility on 9/29/23 with the diagnosis of type 2 diabetes mellitus. Resident #135 had orders dated 9/29/23 for insulin glargine subcutaneous solution pen-injector 100 units/milliliter 35 units at bedtime.	F 842	Insurance Portability and Accountability Act (HIPAA) breach. A violation of HIPAA can lead to termination of employment, a criminal penalty of up to $50,000, and up to one year imprisonment. Effective 11/17/2023, the staff development coordinator and designee educated the licensed nurses and medication aides on documenting in the medication administrator record when medication is given to the residents. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of nursing and designee will perform random audits with the current staff on HIPAA to ensure the staff understands what HIPAA means and the violations 2 times weekly for 12 weeks. The Director of nursing and designee will review the medication administration record during the clinical meeting to ensure accurate documentation of medication the residents receive daily for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. 5. Compliance Date 11/22/2023	

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F 842	Continued From page 37 A review of Resident #135's Medication Administration Record for September 2023 revealed there was no nurse initial documented that the ordered insulin glargine 35 units at bedtime was given on 9/29/23 (Nurse #14). On 10/26/23 at 5:30 pm an interview was conducted with Nurse #14. Nurse #14 stated she was assigned 7 pm to 7 am on 9/29/23 to Resident #135. Nurse #14 stated when she went to administer the resident's ordered insulin for bedtime at approximately 9:30 pm, a warning automated message appeared that the resident was on the maximum dose for this type of insulin. Nurse #14 stated she called the Nurse Practitioner (NP) on call and left a message to check the dosage before administration. Nurse #14 stated she received a call back from the NP on call and the dosage was correct and was administered at approximately 10 pm. Nurse #14 stated she had not documented the insulin administration or the call back from the NP. On 10/27/23 at 2:40 pm the Director of Nursing (DON) was interviewed. The DON stated she was not aware that Resident #135's insulin for administration on 9/29/23 at bedtime was not documented as given.	F 842		
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	F 867		11/22/23

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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, 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

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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; 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

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F 867	Continued From page 40 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; (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 observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification surveys dated 9/19/22, and 5/27/21 and for the complaint investigation surveys dated 12/13/21, 3/31/22, 1/17/23 and 7/6/23 in order to achieve and sustain compliance. These were for recited deficiencies on a recertification survey on 11/2/23. The deficiencies were in the following areas: quality of care, residents are free of significant med error, label/ store drugs and biologicals, food	F 867	F867 1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F684, F760, F761, F812, and F842 on 11//2023. 2. Current residents are potentially affected by this deficiency. 3. The Regional Director of Clinical Services educated the Administrator and	

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F 867	Continued From page 41 procurement, store/prepare/serve - sanitary and resident records- identifiable information. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F684 - Based on record review and interviews of the staff, Nurse Practitioner #2, facility Physician, and Pharmacist, the facility failed to determine or assess the need to continue daily bedside blood sugar monitoring for an insulin dependent resident with numerous comorbidities for 1 of 3 residents reviewed for diabetic blood glucose monitoring. During a previous complaint investigation on 7/6/23 the facility failed to coordinate care for a resident with a seizure disorder. The resident's valproic acid medication dosage was decreased by a Psychiatric Nurse Practitioner who believed it only to be used for mood stabilization and who was unaware the medication was being used for seizure control. There was no communication with the medical provider before the change. The resident seized, was hospitalized, and intubated following the dosage decrease. Prior to transport to the hospital, the resident's seizure was documented to not respond to intramuscular Ativan medication and lasted approximately 28 minutes before emergency medical services arrived for care and transport. This was for one of three sampled residents reviewed for seizure medications. During a complaint investigation on 1/17/23, the	F 867	Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F684, F760, F761, F812, and F842 on 11/17/2023. Education will continue in orientation with new hire. In-person and/or via phone. 4. On 11/17/2023, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Nurse Managers, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, Staff Development Coordinator, Infection Preventionist and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility□s progress, review	

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F 867	Continued From page 42 facility failed to identify the seriousness of 3rd degree facial burns when staff did not provide continuous monitoring of the resident's vital signs or assess the resident to determine the need for nursing or medical interventions until EMS arrived. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents. During a complaint investigation on 3/31/22, the facility failed to complete full body skin assessments, including resident's genitalia, back and lower legs for 1 of 8 sampled residents. During a complaint investigation on 12/13/21, the facility failed to change treatment orders after a podiatry visit, consistently provide wound care, and provide consistent wound care assessments for one of one resident reviewed for a non-pressure wound. 2. F760 - Based on record review, staff, Nurse Practitioner (NP) and Medical Director's interviews, the facility failed to prevent a significant medication error by failing to administer prescribed extra dose of diuretic medication to a resident resulting in two doses of medication being missed for 1 of 1 resident (Resident #128) reviewed for medication errors. During a previous complaint investigation on 7/6/23 the facility failed to correctly identify the diagnosis (indication) for the use of an antiseizure medication. This medication was inadvertently discontinued when the order was corrected to indicate it was used to treat seizures, resulting in a failure to administer 6 consecutive doses of the antiseizure medication for 1 of 3 residents reviewed with a history of seizures.	F 867	corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. 5. Compliance date: 11/22/2023	

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During a previous recertification and complaint investigation on 9/19/22, the facility failed to provide prescribed antiseizure medication for 1 of 10 residents reviewed for medication errors.

3. F761 - Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Accurately label medications (meds) to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Teal Middle Med Cart, Mauve 1 South Med Cart, and Mauve 2 North Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 2) Discard expired medications and/or meds without a legible expiration date on 1 of 4 medication carts (Teal Middle Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 3) Label medications with the minimum information required, including the name of the resident, on 1 of 4 medication carts (Mauve 2 North Med Cart) observed; 4) Store medications in accordance with the manufacturer's storage instructions on 1 of 4 medication carts (Mauve 1 South Med Cart) observed.

During a previous recertification and complaint investigation on 5/27/21, the facility failed to provide the date medications were opened stored in 3 of 6 medication administration carts; failed to remove expired medications stored in 2 of 3 medication storage rooms (Mauve1, Teal North and Teal South halls).

4. 812 - Based on observations and interviews the facility failed to label opened foods and maintain the nourishment refrigerators clean for 3 of 3 nourishment refrigerators. The facility failed

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to maintain the outside of the ice machines, ice scoop and holder clean in 2 of the 3 nourishment rooms (Teal and Mauve #1). These practices had the potential to affect food being served to residents.

During a previous recertification and complaint investigation on 9/19/22, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. This practice had the potential to affect food served to all residents.

5. F842 - Based on review of photographs of facility resident records and anonymous caller interview, the facility failed to protect the private health information for 3 of 4 sampled residents (Resident #119, #128 and #335) by staff photographing confidential medical information. Based on record review and interview of staff, the facility failed to document the resident's insulin administration on the medication administration record for 9/29/23 at bedtime (Resident #135) for 1 of 3 residents reviewed for residents with diabetes.

During a previous recertification and complaint investigation on 9/19/22, the facility failed to maintain accurate documentation in the Medication Administration Record (MAR) for 2 of 10 residents reviewed for accurate medication administration documentation.

During a complaint investigation on 12/13/21, the facility failed to accurately document the provision of wound care on the Treatment Administration Record for 2 of 3 residents reviewed for the provision of wound care.

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F 867	Continued From page 45 During an interview on 10/27/23 at 5:29 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated citations the Administrator stated there was a high turnover with staff. The Administrator further stated there was also high turnover with Director of Nursing staff and accountability was not present, leading to repeated deficiencies. The facility has a new management team, which has oversight and guidance from the corporate. The Administrator indicated the corporate was also directing and helping staff with daily issues and concerns, helping in identifying issues, helping with analysis the root cause, and putting monitoring systems in place. The facility's new staff were working to ensure that high-quality resident care and services were provided. The Administrator stated the old plan would be revisited and analyzed to see where the failures and breakdowns happened. The repeated deficiencies would be monitored closely so that they do not recur.	F 867		