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	345322	A. BUILDING _____ B. WING _____	C 01/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF HENDERSONVILLE	290 CLEAR CREEK ROAD HENDERSONVILLE, NC 28792

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E 000	Initial Comments An unannounced recertification, revisit and complaint investigation survey was conducted 01/02/24 through 01/05/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 91O011.	E 000		
F 000	INITIAL COMMENTS A recertification, revisit and complaint investigation survey was conducted from 01/02/24 through 01/05/24. Event ID# 91O011. The following intakes were investigated: NC00209710, NC00209828, NC00209958, NC00210247, AND NC00209177. 7 of 15 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assess residents to determine if self-administration of medication was clinically appropriate for a resident who wanted to self-administer over-the-counter lubricating eye drops and had a physician order indicating the eye drops may be left at bedside and a resident observed with medicated cream left on a shelf in the resident's room for 2 of 3 sampled residents (Resident #66 and #55). Findings included:	F 554	F554: Resident Self Administration of Medications: 1. On 01/04/2024, Resident #66 and Resident #55 both had a self-administration of medication assessment conducted by the charge nurse and unit manager. There were no negative outcomes identified relating to these assessments. 2. From 01/17/2024 to 01/19/2024, all alert and oriented residents were interviewed by the IDT team to ensure no	1/20/24

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

Electronically Signed | 02/01/2024

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F 554	Continued From page 1 1. Resident #66 was admitted to the facility on 04/20/23 with diagnoses that included dementia and diabetes. The quarterly Minimum Data Set (MDS) dated 11/29/23 revealed Resident #66 had intact cognition. Review of Resident #66's January 2024 Medication Administration Record (MAR) revealed an active physician's order dated 09/11/23 for artificial tears ophthalmic (relating to the eye) solution (type of over-the-counter lubricating eye drops): instill two drops in both eyes three times a day for dry eyes, may keep at bedside, and instill one drop in both eyes every 2 hours as needed for dry eyes. Further review revealed the artificial tears ophthalmic solution was initialed on the MAR as administered daily per physician order. Review of the medical record revealed no documentation that Resident #66 was assessed for self-administration of medications. During an interview on 01/3/24 at 9:48 AM, Resident #66 stated her eyes got tired from working her crossword puzzles throughout the day and the eye drops she received helped. She explained the nurse kept the eye drops in the medication cart and she had to let the nurse know when she needed them so the nurse could put the eye drops in both her eyes. Resident #66 stated she had never been assessed to self-administer medications but would like to keep the eye drops in her room to use as needed. Resident #66 could not recall who she spoke with but stated she had asked staff about leaving the	F 554	other residents wished to self-administer their own prescription drugs or biologicals. Any residents who had wishes to self-administer any medications had assessments completed to begin the process of self-administration. There were no negative outcomes identified relating to these interviews. 3. Beginning on 01/05/2024, 100% of nurses and medication aides were educated by the ADON on the facility policy for medication administration. The education included self-administration evaluations for residents. The education was complete by 1/19/2024. Any newly hired nurses and medication aides beginning after 1/19/2024 will receive this education from the ADON or trained designee during orientation and training prior to working the floor. Beginning on 1/19/2024, the administrator or designee will audit all new admission assessments to ensure all residents who inquire about self-administration of medications will be captured. If any resident chooses to do so, they will be assessed per the facility policy on medication administration. This will be discussed at each quarterly careplan conference to ensure we are capturing any existing residents who may request to self-administer drugs. 4. Beginning after 1/19/2024, residents who are alert and oriented will be interviewed by the Administrator or trained designee to ensure the facility is following	

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F 554	Continued From page 2 eye drops in her room for her to use and was told they couldn't. During an interview on 01/04/24 at 11:30 AM the Unit Manager stated she felt Resident #66 would be able to self-administer her medications safely. The Unit Manager stated if Resident #66 had a physician order indicating the eye drops may be kept at bedside, then a self-administration assessment should have been completed and she was not sure why one wasn't completed for Resident #66. During an interview on 01/04/24 at 3:59 PM, the ADON explained they do not ask residents if they wish to self-administer their medications, it was something the resident had to specifically request, and she was not certain if Resident #66 had requested to self-administer the artificial tears eye drops. The ADON stated if Resident #66 had a physician order indicating the artificial tears eye drops may be left at bedside, then a self-administration of medication assessment should have been done. During interviews on 01/04/24 at 10:25 AM and 01/05/24 at 1:19 PM, the Director of Nursing (DON) explained when a resident wanted to self-administer their medications, a self-administration of medication assessment was completed by the Unit Manager, ADON or herself. She stated if the resident was assessed as being safe, a physician order was obtained for the medication to be kept at bedside, a lock box was placed in the resident's room for them to store the medication and a care plan was developed. The DON stated a self-administration of medication assessment should have been completed for Resident #66 when the physician	F 554	their wishes to self-administer medications at the following frequency: Any variances will be corrected at the time of interview and additional education provided when indicated. i. 10 residents per week for 4 weeks; ii. 5 residents per week for 4 weeks; iii. 3 residents per week for 4 weeks. 5. Beginning after 1/19/2024, the QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F554. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F554. 6. Date of Compliance: 1/20/2024	

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F 554	Continued From page 3	F 554		

order was initiated indicating the artificial tears eye drops may be left at bedside and was not sure how it was overlooked.

2. Resident #55 was admitted to the facility 06/28/21 with diagnoses including Parkinson's disease and diabetes.

The quarterly Minimum Data Assessment (MDS) dated 12/15/23 revealed Resident #55 was cognitively intact.

Review of the medical record revealed no documentation Resident #55 had been assessed for self-administration of medication.

Observations of Resident #55's room on 01/02/24 at 10:37 AM, 01/03/24 at 8:58 AM, and 01/04/24 at 8:24 AM revealed a 5.29-ounce tube of 1% diclofenac cream (an anti-inflammatory medication) sitting on a shelf by her bed.

An interview with Resident #55 on 01/04/24 at 8:24 AM revealed she applied the diclofenac cream to her knees once or twice a day and she last applied the cream on 01/03/24.

An interview with the Director of Nursing (DON) on 01/04/24 at 8:34 AM revealed there were some residents with orders to self-administer medication and she would see if Resident #55 had an order to self-administer diclofenac cream.

A follow-up interview with the DON on 01/04/24 at 10:25 AM revealed Resident #55's brother brought the diclofenac cream to her and did not notify nursing staff that he left the medication in her room. She stated upon admission all residents were notified they could not have

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F 554	Continued From page 4 medication that was not provided by the facility unless there was a Physician's order, but residents and families did not always follow the rules. The DON confirmed Resident #55 had not been assessed to administer the diclofenac cream and the cream should not have been in her room. She explained the process for medications to be self-administered included assessing if the resident could safely administer the medication; and if the resident was able to safely administer the medication a Physician's order was obtained to leave the medication in the room, the medication was placed in a lock box in the resident's room, a key to the lock box was given to the resident and nursing staff kept a key, and a care plan was developed for self-administration of medication.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		1/20/24

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F 565	Continued From page 5 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns voiced by residents during Resident Council meetings for 6 of 7 months reviewed (June 2023, July 2023, August 2023, September 2023, October 2023, and November 2023). Findings included: The Resident Council minutes for the period June 2023 through December 2023 were reviewed and revealed the following: Resident Council minutes dated 06/13/23 noted in part, old business was noted as read and approved and any issues not resolved were moved to new business. Under new business, residents voiced quiet hour needed to be enforced at night as TVs and staff at the nurses' station were too loud and there was too long a	F 565	F565: Resident/Family Group and Response: 1. A Resident Council meeting was held on 1.9.24 by the Activity Director to identify group concerns and initiate investigations and corrective actions. No negative outcomes were identified resulting from this meeting. 2. On 01/15/2024, the Administrator audited the previous 3-months of resident council minutes to review patterns of concerns. Any repeated or patterns of concerns were added to the next resident council agenda (scheduled on 1/23/2024) to discuss improvements or any ongoing concerns. The Administrator interviewed the resident council president on 1/18/2024, to ensure that they felt repeat concerns from the past 3 months had been addressed appropriately and they	

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F 565	Continued From page 6 wait in the dining room for lunch. Resident Council minutes dated 07/11/23 noted in part, old business was read and approved with concerns from previous meeting reviewed and accepted and any issues not resolved were moved to new business. Under new business, residents reported quiet hour was better but staff were still too loud, talking and laughing out in the halls at night. Residents also reported the wait time in the dining room for lunch was better but more help was needed in the dining room during breakfast. Resident Council minutes dated 08/08/23 noted in part, old business was read and approved and any issues not resolved were moved to new business. Under new business, residents voiced there had been no improvement with having enough help in the dining room during meals as assigned staff were always late or did not show up to the dining room at all and evening snacks were not being offered. Resident Council minutes dated 09/12/23 noted in part, old business was read and approved with concerns from previous meeting reviewed and accepted and any issues not resolved were moved to new business. Under new business, residents reported evening snacks were still not being offered and staff were still too noisy at night. Resident Council minutes dated 10/10/23 noted in part, old business was read and approved with concerns from previous meeting reviewed and accepted and any issues not resolved were moved to new business. Under old business it was noted residents reported evening snacks were still not being offered. Under new business, residents voiced meals were served late due to not having staff in the dining room to help and there was nothing documented regarding evening	F 565	were satisfied with the resolutions/progress made in each area. No negative outcomes were identified resulting from this audit. 3. On 01/16/2024, the management team was educated on the policy and procedure Guest/Resident Council by the Administrator. The education also included the administrator□s expectations of having documented evidence of planned resolutions to grievances and following up with those during resident council. Any newly hired managers beginning after 1/19/2024 will receive this education from the Administrator or trained designee during orientation and training prior to working the floor. Continuing on 1/23/2024, the administrator will attend resident council meetings (and ask for permission each time from the resident council to attend) in order to personally ensure the resident council members are satisfied with resolutions to reported concerns. During each meeting, the administrator will offer a second resident council meeting for the month, if desired by the residents, in order to increase communication regarding the ongoing grievances or ideas for facility improvement. Variances will be corrected at the time of meeting and additional education provided as indicated. 4. Beginning after 1/19/2024, the Administrator will audit each months□ resident council minutes to ensure	

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F 565	Continued From page 7 snacks. Resident Council minutes dated 11/14/23 noted in part, old business was read and approved with concerns from previous meeting reviewed and accepted and any issues not resolved were moved to new business. Under new business, residents reported the noise at night had improved but TV's were still too loud. Resident Council minutes dated 12/26/23 noted in part, old business was read and approved with concerns from previous meeting reviewed and accepted and any issues not resolved were moved to new business. Under new business, residents reported staff were still too noisy at night. The facility's grievance logs for the period June 2023 through November 2023 were reviewed and noted as resolved. The grievances filed on behalf of the members of the Resident Council following the monthly meetings revealed the following: A concern form dated 06/13/23 regarding lunch meals being served late in the dining room. The resolution noted audits of the lunch meal service were conducted on 06/14/23, 06/15/23 and 06/16/23 by the Certified Dietary Manager with no concerns identified. A concern form dated 06/13/13 regarding the enforcement of quiet hour due to TVs and staff at the nurses' station being too noisy at night. The resolution noted staff education was provided to all staff. A concern form dated 07/11/23 regarding staff being too loud at night. The resolution noted staff education was provided. A concern form dated 07/11/23 regarding more staff needed in the dining room during breakfast. The resolution noted strategies were implemented.	F 565	grievances were filed to initiate a satisfactory resolution for the resident council. The audit period will be for 3-months. 5. Beginning after 1/19/2024, the QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F565. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F565. 6. Date of Compliance: 1/20/2024	

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A concern form dated 08/08/23 regarding not enough staff in the dining room during meals or assigned staff not showing up at all. The resolution noted dining room assignments would be made and staff notified of assignment at start of shift.
A concern form dated 08/08/23 regarding snacks not being offered/passed at night. The resolution noted a snack cart was made available for staff to use on the halls to pass out evening snacks to the residents.
A concern form dated 09/12/23 regarding staff being too loud at night. The resolution noted interviews were conducted with residents on all halls with most stating the noise level varied at night but did not keep them from being able to sleep or woke them up and staff education regarding keeping noise level at a minimum on the halls at night.
A concern form dated 09/12/23 regarding evening snacks not being passed to residents at night. The resolution noted nursing staff were reeducated on when to pass the evening snacks provided by dietary.
There was no concern form dated 10/10/23 regarding evening snacks not being passed on the facility's grievance log.
A concern form dated 10/10/23 regarding not having enough help in the dining room during meals. The resolution noted staff were assigned to dining room prior to meals and overhead meal announcements would be made for assigned staff to report to the dining room.
There was no concern form dated 11/14/23 on the facility's grievance log regarding TV's still too loud at night.

The facility grievance log for December 2023 was reviewed and noted the grievances filed on behalf

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of the members of the Resident Council following the monthly meeting were in the process of being investigated.

A Resident Council group interview was conducted on 01/04/23 at 9:35 AM with Resident #3, Resident #33, Resident #35, Resident #53 and Resident #56 in attendance. The residents all stated they felt facility staff did not really address their concerns because they often brought up the same issues during the monthly meetings as any improvement they noticed was usually short-term. The residents voiced ongoing concerns with staff not respecting quiet hour at night/early morning by slamming doors and talking too loudly, not enough staff in the dining room during meals, and evening snacks were not being offered consistently. The residents all agreed when they brought up the same concerns during Resident Council meetings, the only response they typically received from staff was "we are working on it" but never any satisfactory resolution. The residents stated they would like to know they are being heard and receive feedback from administration on the efforts that had been made or attempted to resolve their concerns.

During an interview on 01/04/23 at 12:36 PM, the Activity Director revealed she had been in her current position since October of 2023 and explained when concerns were brought up during Resident Council meetings, she wrote them on a concern form and turned into administration to address. The Activity Director stated the repeated concerns residents voiced most often during the Resident Council meetings were the noise level at night and not enough staff in the dining room during meals. She stated the

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F 565	Continued From page 10 concerns voiced during the previous meeting and steps being taken to address the concerns were discussed as old business during the next Resident Council meeting. If residents reported the concern(s) had not improved, the concern was noted under new business and a new grievance form was completed. During an interview on 01/05/24 at 12:17 PM, the Administrator explained he had started his employment at the facility the end of November 2023 and had met with the Resident Council during the monthly meeting just last week. He stated he was the Grievance Official for the facility and was currently working on addressing the issues brought up during the recent Resident Council meeting which he acknowledged some of the issues were concerns that had been voiced during previous Resident Council meetings. The Administrator stated he felt the repeated concerns were not effectively resolved and/or the resolutions were not monitored as they should have been. He stated going forward, any minor concerns voiced would be assigned to the appropriate Department Manager to address and for systemic concerns, he and the Director of Nursing would work together to address. He explained systemic changes may take longer to get results but he planned on opening the communication with the residents to provide them with updates and timelines so they felt part of the resolution process.	F 565		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		1/20/24

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F 584	Continued From page 11 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the	F 584	F584: Safe/Clean/Comfortable/Homelike	

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F 584	Continued From page 12 facility failed to maintain clean overbed tables (room 104); maintain clean ceiling vents (bathroom of 104, 107, 112); maintain walls in good repair (rooms 104, 107, 205, and 207); maintain clean privacy curtains (rooms 106, 107, 112 and 205); maintain a clean bedside commode (shared bathroom of 107); and maintain a clean mechanical lift (lift for 100 and 200 halls) for 2 of 4 halls reviewed for environment (100 hall and 200 hall). Findings included: 1. An observation of the walls in rooms 205 on 01/02/2024 at 11:22 AM revealed a screw sticking out of the wall next to the window. The screw stuck out a half inch from the wall and was screwed into a concrete wall that was at face level for residents in a wheelchair. Additional observation of the wall in room 205 on 01/02/2024 at 11:22 AM also revealed linear scrapes to the wallpaper with exposed sheet rock. Additional observation of the wall in room 207 on 01/02/2024 at 10:51 AM revealed linear scrapes to the wallpaper with exposed sheet rock. Final observations were made in room 205 and 207 on 01/05/2024 11:22 AM revealed the screw in the wall, scrapes in the wallpaper and exposed sheet rock. An interview with the Maintenance Director on 01/05/24 at 3:49 PM revealed he was trying to do away with wallpaper throughout the facility due to it tearing easily, but he was not aware of the torn wallpaper in rooms 205 and 207. The	F 584	Environment: 1. Between 1/8/2024 and 1/19/2024, the maintenance director and environment services director oversaw that the corrections from the annual survey were completed. No negative outcomes were identified resulting from these observations. The corrections included: i. Cleaning overbed tables in Room 104 ii. Cleaning ceiling vents in the bathroom of 104, 107, and 112 iii. Repairing walls in rooms 104, 107, 205, and 207 iv. Cleaning privacy curtains in rooms 106, 107, 112, and 205 v. Ensuring the commode in 107 was clean. vi. Ensuring the mechanical lifts were cleaned. vii. Removing the screw from the wall in 205. 2. The facility management team completed a 100% room round audit from 1/17/2024 to 1/19/2024 to look for areas of deficiencies. Any concerns noted were documented and then audited by the administrator on 1/19/2024. Any concerns noted were reported to the maintenance director and environmental service director by the administrator for corrections to be scheduled. Any correction outside of the maintenance director and environmental services directors□ abilities will result in contractors being consulted for corrections. No negative outcomes were identified resulting from this audit.	

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F 584	Continued From page 13 Maintenance Director had not been notified about the screw sticking out of the wall. When was shown to him it was taken care of right away. He reported that staff are supposed to alert the department with any possible hazards, but this was the first he had heard about it. An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected walls in resident rooms to be in good repair and any screws would be removed from the walls when decorations were taken down. 2. An observation of the privacy curtain closest to the entry door of room 205 on 01/02/24 at 11:22 AM revealed brown stains. Additional observations of the privacy curtains in room 205 on 01/05/2024 at 3:40 PM revealed that the brown stains were still present. An interview with Housekeeper #1 on 01/05/24 at 3:11 PM revealed housekeeping changed privacy curtains when they were notified of the curtains being soiled and he had not been notified of any privacy curtains that needed to be changed. An interview with the Director of Environmental Services on 01/05/24 at 3:49 PM revealed privacy curtains were changed when a resident was discharged or when housekeeping was notified of the curtains being soiled. He stated housekeeping had not been notified of the need to change privacy curtains in room 205. An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected privacy curtains to be clean.	F 584	3. On 1/16/2024, the facility management team was educated by the administrator on the expectations of having a homelike environment and the team□s responsibility for room rounding, to ensure work orders are being completed and the facility is promoting a homelike environment. 4. Beginning after 1/19/2024, the Facility Tour Audit Tool rounding checklist will be completed by the administrator or trained designee to ensure the facility is addressing deficiencies related to a homelike environment. Variances will be corrected/scheduled at the time of audit and additional education provided as indicated. Audits will be conducted at the following frequency by the Administrator or trained designee at the following frequency: i. 5 days per week for 4 weeks; ii. 3 days per week for 4 weeks; iii. 1 day per week for 4 weeks. 5. Beginning after 1/19/2024, the QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F584. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F584. 6. Date of Compliance: 1/20/2024	

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3. An observation of both overbed tables in room 104 on 01/02/24 at 10:42 AM revealed dried debris on the frames.

Additional observations of the overbed tables in room 104 on 01/03/24 at 9:03 AM, 01/04/24 at 8:30 AM, and 01/05/23 at 2:55 PM revealed dried debris on the frames.

An interview with Housekeeper #1 on 01/05/24 at 3:11 PM revealed daily cleaning of resident rooms included cleaning overbed tables when they were dirty.

An interview with the Director of Environmental Services on 01/05/24 at 3:49 PM revealed housekeeping and nursing were responsible for cleaning overbed tables when they were dirty.

An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected overbed tabled to be clean and free of debris.

4. (a). An observation of the bathroom ceiling vent in room 104 on 01/02/24 at 10:46 AM revealed a layer of white dust build-up on the vent.

Additional observations of the bathroom ceiling vent in room 104 on 01/03/24 at 9:03 AM, 01/04/24 at 8:39 AM, and 01/05/24 at 2:55 PM revealed a layer of white dust build-up on the vent.

(b). An observation of the bathroom ceiling vent in room 107 on 01/02/24 at 11:02 AM revealed a thick layer of white dust build-up on the vent.

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F 584	Continued From page 15	F 584		

Additional observations of the bathroom ceiling vent in room 107 on 01/03/24 at 8:54 AM, 01/04/24 at 8:14 AM, and 01/05/24 at 3:01 PM revealed a thick layer of white dust build-up on the vent.

(c). An observation of the bathroom ceiling vent in room 112 on 01/02/24 at 4:06 PM revealed a layer of white dust build-up on the vent.

Additional observations of the bathroom ceiling vent in room 112 on 01/03/24 at 8:48 AM, 01/04/24 at 8:46 AM, and 01/05/24 at 3:07 PM revealed a layer of white dust build-up on the vent.

An interview with Housekeeper #1 on 01/05/24 at 3:11 PM revealed bathroom ceiling vents were cleaned by housekeeping any time dust was noted.

An interview with the Director of Environmental Services on 01/05/24 at 3:49 PM revealed ceiling vents were cleaned by housekeeping and maintenance and should be cleaned when dust was noted.

An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected bathroom ceiling vents to be clean and free of dust.

5. (a). An observation of the wall in room 104-A on 01/02/24 at 10:42 AM revealed linear scrapes to the wallpaper with exposed sheet rock.

Additional observations of the wall in room 104-A on 01/03/24 at 9:03 AM, 01/04/24 at 8:39 AM, and 01/05/24 at 2:55 PM revealed linear scrapes to the wallpaper with exposed sheet rock.

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(b). An observation of the wall in room 107-A on 01/02/24 at 11:00 AM revealed an approximately 3-inch area of missing wallpaper with exposed sheet rock.

Additional observation of the wall in room 107-A on 01/03/24 at 8:54 AM, 01/04/24 at 8:14 AM, and 01/05/24 at 3:01 PM revealed an approximately 3-inch area of missing wallpaper with exposed sheet rock.

An interview with the Maintenance Director on 01/05/24 at 3:49 PM revealed he was trying to do away with wallpaper throughout the facility due to it tearing easily, but he was not aware of the torn wallpaper in rooms 104 and 107.

An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected walls in resident rooms to be in good repair.

6. (a). An observation of the privacy curtain closest to the entry door of room 106 on 01/02/24 at 10:53 AM revealed scattered brown stains.

Additional observations of the privacy curtain closest to the entry door of room 106 on 01/03/24 at 9:00 AM, 01/04/24 at 8:16 AM, and 01/05/24 at 2:58 PM revealed scattered brown stains.

(b). An observation of the privacy curtain closest to the entry door of room 107 on 01/02/24 at 11:00 AM revealed scattered brown stains.

Additional observations of the privacy curtain closest to the entry door of room 107 on 01/03/24 at 8:54 AM, 01/04/24 at 8:14 AM, and 01/05/24 at 3:01 PM revealed scattered brown stains.

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(c). An observation of the room divider curtain in room 112 on 01/03/24 at 12:28 PM revealed scattered brown stains.

Additional observations of the room divider curtain in room 112 on 01/04/24 at 8:46 AM and 01/05/23 at 3:07 PM revealed scattered brown stains.

An interview with Housekeeper #1 on 01/05/24 at 3:11 PM revealed housekeeping changed privacy curtains when they were notified of the curtains being soiled and he had not been notified of any privacy curtains that needed to be changed.

An interview with the Director of Environmental Services on 01/05/24 at 3:49 PM revealed privacy curtains were changed when a resident was discharged or when housekeeping was notified of the curtains being soiled. He stated housekeeping had not been notified of the need to change privacy curtains in rooms 106, 107, or 112.

An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected privacy curtains to be clean.

7. An observation of the bedside commode in the shared bathroom of room 107 on 01/02/24 at 11:00 AM revealed brown debris on the bowl of the bedside commode.

Additional observations of the bedside commode in the shared bathroom of room 107 on 01/03/24 at 8:54 AM, 01/04/23 at 8:14 AM, and 01/05/24 at 3:01 PM revealed brown debris on the bowl of the bedside commode.

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F 584	Continued From page 18 An interview with Housekeeper #1 on 01/05/24 at 3:11 PM revealed bathrooms, including bedside commodes were cleaned daily. An interview with the Director of Environmental Services on 01/05/24 at 3:49 PM revealed housekeeping cleaned bathrooms daily, but there were some resident bathrooms that needed to be cleaned multiple times a day. He indicated the shared bathroom of room 107 was not on housekeeping's list to be cleaned multiple times a day and he wasn't sure why the bedside commode contained brown debris. An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected bedside commodes to be clean and free of debris. 8. An observation of the mechanical lift for 100 and 200 halls on 01/02/24 at 11:04 AM revealed dried debris to the frame of the lift. Additional observations of the mechanical lift for 100 and 200 halls on 01/03/24 at 8:50 AM, 01/04/24 at 8:43 AM, and 01/05/24 at 3:14 PM revealed dried debris to the frame of the lift. An interview with the Maintenance Director on 01/05/24 at 3:49 PM revealed maintenance was responsible for cleaning lifts when they were dirty. He stated the lift on 100 and 200 halls had last been sprayed off on 01/04/24. An interview with the Administrator on 01/05/24 at 3:49 PM revealed he expected mechanical lifts to be clean and free of debris.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation	F 602		

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F 602	Continued From page 19 CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect residents' rights to be free from misappropriation of narcotic pain medication for 2 of 2 residents (Resident #94 and Resident #96) reviewed for misappropriation of resident property. Findings included: Review of the facility's Abuse Prohibition Policy last revised 09/09/22 indicated the facility would ensure residents were free from misappropriation of property. 1. (a) Resident #96 was admitted to the facility 09/27/23 with diagnoses including heart failure and diabetes and was discharged to the community on 11/10/23. Review of Resident #96's Physician orders revealed an order dated 11/04/23 for oxycodone (narcotic) 10 milligrams (mg) one tablet every 4 hours as needed for pain scale of 4 to 6 for 7 days. Review of Resident #96's November 2023 Medication Administration Record (MAR)	F 602	Past noncompliance: no plan of correction required.	

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revealed she last received oxycodone 10 mg on 11/10/23 at 8:12 AM.

The discharge Minimum Data Set (MDS) assessment dated 11/10/23 revealed Resident #96 was cognitively intact and received opioid (narcotic) medication during the 7-day MDS assessment period.

1. (b) Resident #94 was admitted to the facility 09/07/23 with diagnoses including periprosthetic (fracture associated with an orthopedic implant) fracture around internal prosthetic right hip and neuropathy (nerve pain) and was discharged to the community on 11/09/23.

Review of Resident #94's Physician orders revealed an order dated 10/25/23 for oxycodone (narcotic pain medication) 5 milligrams (mg) one tablet by mouth every 4 hours as needed for pain for 14 days.

Review of Resident #94's November 2023 Medication Administration Record (MAR) revealed she last received oxycodone 5 mg on 11/07/23 at 9:36 AM.

The discharge Minimum Data Set (MDS) assessment dated 11/09/23 revealed Resident #94 was cognitively intact and received opioid (narcotic) pain medication during the 7-day MDS assessment period.

An interview with Nurse #6 on 01/04/24 at 5:01 PM revealed she was working 11/10/23 on the 7:00 AM to 7:00 PM shift on the 200 hall. She explained that Resident #96's assigned nurse (Nurse #7) on the 400 hall was on a break when Resident #96 was ready to be discharged, so she

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discharged Resident #96. Nurse #6 stated she reviewed all prescriptions and discharge instructions with Resident #96 and the resident verbalized understanding of the instructions and left the facility with her husband. She stated later in the day on 11/10/23 Resident #96 called the facility and stated she had not been sent home with a prescription for pain medication and had not received her oxycodone from the facility when she was discharged. Nurse #6 stated no prescription for oxycodone was included in Resident #96's discharge prescriptions and she was not aware that Resident #96 had an open card of oxycodone on the medication cart since she was not assigned to care for Resident #96. She stated she did not have the keys to medication cart on 400 hall at any time during her shift on 11/10/23, but when Resident #96 called and said she didn't receive her pain medication she notified Unit Manager #1 that Resident #96 had been discharged home on 11/10/23 and called the facility after she left to ask about her pain medication, since she did not receive a prescription or the card of her pain medication.

A telephone interview was attempted with Nurse #7 on 01/03/24 at 3:05 PM. He stated he had to pick a child up from school and to call him back in 15 minutes. A return call was attempted on 01/03/24 at 3:23 PM and no one answered the telephone and a voicemail was left asking him to return the call. No return telephone was received during the investigation.

In an interview with Medication Aide (MA) #1 on 01/04/24 at 3:28 PM he confirmed he worked the 7:00 AM to 7:00 PM shift on 11/09/23 on 400 hall. He stated the narcotic count was correct at the beginning and end of his shift and the medication

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cart keys were never out of his sight on 11/09/23. MA #1 stated he was asked by the facility to obtain a drug screen on 11/11/23, which was negative for opioids.

In a telephone interview with Nurse #8 on 01/04/24 at 8:41 PM she confirmed she was assigned to the 400 hall on 11/09/23 for the 7:00 PM to 7:00 AM shift. She stated the narcotic medication count was correct at the beginning and end of her shift and the medication cart keys were never out of her sight during her shift on 11/09/23. Nurse #8 stated she was asked by the facility to obtain a drug screen on 11/11/23, which was negative for opioids.

An interview with Unit Manager #1 on 01/05/24 at 8:43 AM revealed she was notified on 11/10/23 Resident #96 was discharged home and called back to the facility after she left stating she did not receive a prescription for pain medication or a card of pain medication. She explained it was facility policy to send an opened card of medication home with the resident at discharge and if the medication card had not been opened it was returned to the facility's pharmacy. Unit Manager #1 stated she looked in the 400 hall narcotic box and could not locate a card of oxycodone for Resident #96 and could not locate the sign out sheet in the narcotic book for Resident #96's oxycodone. She reported she asked Nurse #7 where Resident #96's card of oxycodone and the sign out sheet for the medication were and he said he didn't know, but the narcotic count had been correct that morning. She stated she immediately notified the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). Unit Manager #1 stated she, the ADON, and DON began looking everywhere

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for the missing card of medication and the narcotic sign out sheet. She stated when Resident #96's medication card and sign out sheet could not be located, the DON notified the police department and told Nurse #7 he needed to leave and go get a drug screen at the local urgent care. Unit Manager #1 stated she, the DON, and the ADON continued looking for Resident #96's medication and sign out sheet and the ADON happened to see the sign out sheet for Resident #94's oxycodone in the shred box torn in pieces. She stated when they removed the narcotic sign out sheet for Resident #94's oxycodone from the shred box they also happened to find the label of the medication card for Resident #96's oxycodone 10 mg. Unit Manager #1 stated the narcotic sign out sheet and oxycodone medication were never located for Resident #96 and the oxycodone medication was never located for Resident #94.

An interview with the ADON on 01/04/24 at 3:34 PM revealed she was notified Resident #96 had been discharged home on 11/10/23 and did not receive a prescription for pain medication or her opened card of pain medication. She explained Unit Manager #1 told her she could not find the narcotic sign out sheet or the card of oxycodone. The ADON stated she, the DON, and Unit Manager #1 began looking everywhere for Resident #96's narcotic sign out sheet and the oxycodone pills and could not locate either one. She stated she searched the shred bin and happened to see the narcotic sign out sheet for Resident #94 torn in pieces and the label of the medication card for Resident #96's oxycodone 10 mg. The ADON stated they were able to tape the narcotic sign out sheet for Resident #94's oxycodone back together but they were unable to

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locate the oxycodone pills for Resident #96 and Resident #94, and they were never able to locate the narcotic sign out sheet for Resident #96's oxycodone. She stated the DON notified the police department of the missing medications and sent Nurse #7 to the local urgent care to obtain a drug screen. The ADON stated she called the urgent care center to notify them that a facility employee would be there shortly to obtain a drug screen and she was informed there was no one present at the urgent care center that knew how to perform a drug screen. She stated as soon as she got off the telephone with urgent care, she notified the DON that urgent care wasn't going to be able to do the drug screen on 11/10/23. The ADON stated facility staff continued to look for the oxycodone pills and narcotic sign out sheet for both Resident #94 and Resident #96, and one nurse happened to see a pink pill on the floor at the nurse's station where Nurse #7 had been sitting earlier. She stated the DON secured the pill and did not know if the pharmacy had the pill or if the DON kept the pill.

An interview with the Director of Nursing (DON) on 01/03/24 at 3:00 PM revealed as soon as she became aware of the missing card of oxycodone pills for Resident #96 in November 2023, she, the ADON, and Unit Manager #1 began looking everywhere. She explained while they were looking for the oxycodone pills and narcotic sign out sheet for Resident #96, they discovered the label of the medication card for Resident #94's oxycodone 5mg in the shred bin. The DON stated the narcotic sign out sheet for Resident #96's oxycodone 10 mg was never located and the oxycodone pills for both Resident #94 and Resident #96 were never located. She stated while the search for the medications and sign out

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sheets was ongoing, she notified the police department of the missing medication and told Nurse #7 to go to urgent care to obtain a drug screen. The DON stated shortly after Nurse #7 left the facility he called her and stated he had a flat tire. She stated she told Nurse #7 she would come and get him, and he declined. The DON stated a few minutes later she received another call from Nurse #7 informing her that his car had been side-swiped and a tow truck was coming to get his vehicle. She stated a short time later Nurse #7 called her again and informed her that his girlfriend picked him up and refused to drive him anywhere to obtain a drug screen. The DON stated Nurse #7 texted her results of a drug screen obtained 11/11/23 which was negative for opioids. She stated while staff continued to look for the missing medications for Resident #96 and Resident #94 and the narcotic sign out sheet for Resident #96 the night of 11/10/23, a staff member happened to see a pill on the floor in the nurse's station where Nurse #7 sat during his shift. The DON stated the pill was determined to be an oxycodone 10 mg pill by pharmacy and she secured the pill. She stated Medication Aide (MA) #1 who worked on the 400 hall on 11/09/23 on the 7:00 AM to 7:00 PM shift and Nurse #8 who worked on the 400 hall on 11/09/23 on the 7:00 PM to 7:00 AM shift were interviewed and confirmed the narcotic count was correct when they began their shift and when their shift ended. The DON stated both MA#1 and Nurse #8 were drug screened on 11/11/23 and were negative for opioids. The DON stated it was determined 26 oxycodone 10 mg pills could not be located for Resident #96 and 14 oxycodone 5 mg pills could not be located for Resident #94. She stated a 24-hour/5-day investigation was completed and Nurse #7 was terminated. The DON stated an

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audit of all resident narcotics was completed, including residents who had been discharged the past month, and no other residents had missing narcotics. She stated a root cause analysis was conducted 11/11/23 and determined that if a system of oversight for residents with narcotics who were discharged or expired had been developed, the diversion likely would not have occurred. The DON stated all licensed nursing personnel and medication aides were in-serviced regarding narcotic inventory procedures. She stated she filed an online complaint with the North Carolina Board of Nursing regarding Nurse #7 and the missing narcotics.

An interview with the Administrator on 01/05/24 at 3:49 PM revealed he was not employed at the facility when this incident occurred.

The facility provided the following corrective action plan with a completion date of 11/13/23:

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

-A root cause analysis was conducted and completed 11/11/23 and determined to be caused by a lack of oversight by nursing administration regarding narcotic medications when residents were discharged.

-All licensed nursing personnel and medication aides received training regarding controlled narcotic inventory procedures. Implementation date: 11/11/23. Targeted date of completion 11/13/23.

How corrective action will be accomplished for

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the residents having the potential to be affected by the same deficient practice:

-An inventory of narcotic medications for current residents and residents that had been discharged within the past month and there were no other missing narcotics identified. Implementation date: 11/10/23. Targeted date of completion: 11/13/23.

Measures that will be put in place and/or what systemic changes will be made to ensure the deficient practice does not recur:

-All licensed nurses and medication aides received training on the process for narcotic medications when a resident was discharged. Implementation date 11/11/23. Targeted date of completion 11/13/23.

-The Director of Nursing (DON) or her designee will conduct random narcotic counts five times a week for 2 weeks, then three times a week for 2 weeks, then weekly for one month, then bi-weekly for one month, and randomly thereafter. Implementation date: 11/11/23. Targeted date of completion: ongoing.

How will the facility monitor performance to ensure that solutions are sustained? What is the plan to ensure that corrective action is achieved and sustained? The plan must be implemented and the correction action evaluated for effectiveness.

-An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was conducted to review the plan for storing narcotics for discharged residents by the DON, ADON,

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Regional Consultant, and Administrator. Implementation date: 11/13/23. Targeted completion date:0 2/29/24.

-Results of audits will be reviewed by Administrator weekly and discussed at monthly QAPI meeting for 3 months or until resolved. Implementation date: 11/13/23. Targeted completion date: 02/29/24.

The facility's corrective action plan with a correction date of 11/13/23 was validated onsite by record review, observations, and interviews with nursing staff.

Nursing staff confirmed they received in-service training and in-person audits regarding the procedure for handling narcotics when a resident is discharged conducted by the DON, ADON, and Unit Manager #1. Nurses explained the following as education they received:

-When empty narcotic medication cards and narcotic sign out sheets were removed from the medication cart they were to be labeled with the resident's name and the number of cards removed.

-If a resident discharged/expired during their shift the DON, ADON, or Unit Manager #1 were to be notified for immediate removal of medication from the cart.

-If a resident was discharged/expired after business hours or on the weekend the DON was to be called and notified of the resident's name and how many medications were in the medication card.

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F 602	Continued From page 29 -Empty narcotic medication cards and accompanying sign out sheets were to be placed in the DON's mailbox. -When residents with opened narcotic medication cards were discharged a copy of the medication card was to be made and the resident/responsible party was to sign the copy and place in the DON's mailbox. -If a narcotic discrepancy was noted during shift count, the supervisor was to be notified immediately.	F 602		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and Physician interviews the facility failed to follow a Physician's order for 1 of 1 resident (Resident #13). Findings included: Resident #13 was admitted to the facility on 09/23/2020 with diagnoses including anxiety, and dementia without behavioral or psychotic disturbance. The quarterly Minimum Data Set (MDS) dated 10/26/2023 revealed Resident #13 had moderate cognitive impairment with disorganized thinking and verbal/vocal symptoms of screaming and	F 658	F658: Services Provided Meet Professional Standards: 1. Resident #1 had no negative outcome resulting from this observation. Resident #1 continues to receive medication per physician's orders. 2. On 1/6/2024, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) audited 100% of narcotic sheets compared to current physician orders in the EMR. There were no concerns noted. 3. Beginning on 01/05/2024, 100% of nurses and medication aides were	1/20/24

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F 658	Continued From page 30 disruptive sounds. An observation of Resident #13 on 01/02/2024 at 4:32 PM revealed the resident was confused, and unable to answer some direct questions. While speaking to Resident #13, the resident could not answer about any feelings of increased anxiety symptoms. A review of Resident #13's Physician orders on 11/20/23 revealed a dose change for the antianxiety medication Clonazepam, generic for (Klonopin) from 0.5 milligrams (mg) 1 tablet by mouth three times a day to 1mg tab by mouth three times a day. A review of the medication-controlled substance sheets showed that the facility staff had been giving a dose of 0.5mg instead of 1mg. This was verified after reviewing the control substance sign out sheet. The document showed staff were giving 0.5mg tabs and signing out one instead of two tablets. Resident #13 was given the wrong dose from 11/20/23 through 12/7/23. The new medication card arrived at the facility on 12/7/23 on 7 PM to 7AM shift for 1 mg tablets from the pharmacy and no further errors were noted. An interview with Medication Aid (MA) #1 on 01/04/24 at 11:14 AM revealed that she was unaware that the resident's dose had changed. MA#1 stated that old cards will be used if a dose can be given per new orders. MA#1 stated that if a dose has changed, they will place a red sticker on the top of the card to alert staff, but she does not remember seeing any sticker and states no one told her in the report that the dose had changed. She stated if there is a discrepancy with the control sheets that the charge nurse should be notified immediately.	F 658	educated by the ADON on the facility policy for Medication Administration. The education included following physician orders for medication administration.. The education was complete by 1/19/2024. Any newly hired nurses or medication aides beginning after 1/19/2024 will receive this education from the ADON or trained designee during orientation and training prior to working the floor. 4. Beginning after 1/19/24, the DON or trained designee will audit the narcotic sheets compared to current physicians' orders in the EMR to ensure compliance with F658. Variances will be corrected at the time of audit and additional education provided as indicated. The audits will be conducted at the following frequency: a. 10 orders for narcotics/controlled substances per week for 4 weeks; b. 5 orders for narcotics/controlled substances per week for 4 weeks; c. 3 order for narcotics/controlled substances per week for 4 weeks. 5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F658. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F658.	

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F 658	Continued From page 31 An interview with Nurse #3 on 1/4/24 at 11:31 AM revealed that it is common practice to use current medication cards after a dose change is communicated, and a red sticker is placed on the affected medication card. The nurse stated she was not made aware of any concerns with resident #13 medication, so she had not addressed the issue. Nurse #3 also stated that the employees should only depend on the MAR and never what the top of the medication card states. The nurse stated if they had followed the MAR and compared the card the mistake would not have happened. An interview with the Medical Director (MD) on 1/5/24 at 10:37 AM revealed that he was unaware that the resident was not consistently getting the correct dose of medication. The MD stated that he was not aware of any increase in anxiety or behaviors from resident #13 from 11/20/23 through 12/7/23 and did not feel this was a significant medication error. MD reported that the facility had been reporting increase anxiety and behaviors so an increase in Clonazepam was ordered. MD stated that "he did not feel this error would have caused any adverse effects for the resident. An interview with MA #2 on 1/5/24 at 2:52 PM revealed that no one informed her of the medication change and there was no red sticker on the card, so she did not know that it had changed. The employee stated, "I messed up I should have paid more attention and asked the nurse before I gave it, guess I just missed it." The employee was asked what should have been done when the dose changed, she stated "It should have been passed on in the report and a	F 658	6. Date of Compliance: 1/20/2024	

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F 658	Continued From page 32 red sticker should have been placed on the card to alert staff to the change". An interview with the Director of Nursing (DON) on 01/05/24 at 12:51 PM revealed she was not aware of the situation where resident #13 did not receive the ordered dose of medication. The DON expected that staff would compare the orders on the MARs with the card they are taking the medication from before administering any medication. The DON stated that the facility does use red dot stickers to indicate a change in medication orders. The DON would have expected staff to identify the medication error and bring it to the DON so the issue could be fixed. An interview with the Administrator on 01/05/24 at 4:28 PM revealed the expectation is for the staff to identify any errors or concerns and bring them to the supervisor. The DON should be aware of the concern as soon as possible and bring it to him so they can address the issue and get an explanation of why it occurred.	F 658		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		1/20/24

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F 756	Continued From page 33 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Consultant Pharmacist, and Medical Director interviews, the facility failed to follow up on the monthly pharmacist consultation reports for 1 of 4 residents reviewed for unnecessary medications for Resident #38. Finding included: Resident #38 was admitted to the facility on 5/31/23 with diagnoses that included mood disorder/behaviors.	F 756	F756: Drug Regiment Review: 1. The attending physician signed and made determinations for the pharmacist recommendations for Resident #38 on 1/11/2024. No negative outcome was identified as a result of this observation. 2. On 1/15/2024, the previous 3 months of pharmacist recommendations were audited by the Pharmacy Consultant to ensure that there were no other unaddressed pharmacist	

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F 756	Continued From page 34 An active physician's order dated 5/31/23 for Resident #38 read, Seroquel (an antipsychotic medication) 25 milligrams (mg) by mouth at bedtime and Seroquel 12.5mg every morning for mood disorder/behaviors. A review of a "Consultation Report" issued on 11/3/23 read, Resident #38 "has received an antipsychotic Seroquel 12.5mg in the morning and 25mg at bedtime for management of mood disorder/behaviors, since 5/31/23. Please attempt a Gradual Dose Reduction (GDR) for Seroquel to one time a day." The bottom of the form where the provider would accept or deny the GDR recommendation and sign the form was not signed and no physician progress was noted stating why GDR was declined. Review of Consultation reports from 08/08/2023 and 09/06/2023 were also assessed and did not have physician's signature or progress note for the reason the GDR was declined. The quarterly Minimum Data Set (MDS) assessment dated 11/15/23 revealed Resident #38 was cognitively intact and received antipsychotics daily during the 7-day MDS assessment period. The Medication Administration Records (MARs) for August 2023 September 2023 November 2023, and December 2023, revealed Resident #38 received Seroquel 12.5 mg in the morning and 25mg at bedtime daily as ordered. During a phone interview on 1/5/2024 at 12:44 PM, the Consultant Pharmacist explained he typically made notes when completing his	F 756	recommendations. There were no unaddressed concerns per the pharmacist. 3. The attending physician for Resident #38 was provided with verbal and written education on the F756 regulation by the Administrator on 1.18.24. All attending providers were provided with education on the F756 regulation by the Administrator on 1/18/2024. Any newly hired attending providers beginning after 1/19/2024 will receive this education from the Administrator prior to working the floor. 4. Beginning after 1/19/2024, the Administrator will audit the monthly report from the pharmacist entitled Medication Regimen Review Summary for 3 months to ensure the facility has received physician response for each pharmacist recommendation. Variances will be corrected at the time of audit and additional education provided as indicated. 5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F756. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F756.	

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F 756	Continued From page 35 monthly medication reviews and followed up on any outstanding recommendations verbally during the exit call with the Director of Nursing (DON). The Consultant Pharmacist confirmed he submitted a recommendation for a GDR of Seroquel for Resident #38 for 08/08/23, 09/06/23, and 11/03/23. The Pharmacist's expectations would be if a physician does not respond he expects the Director of Nursing to follow up. When he returns and nothing has been completed on the previous recommendations, he will submit another GDR to the facility and the physician. During an interview on 1/5/24 at 10:37 AM, the Medical Director (MD) explained that he was not aware that the attending physician had not been addressing the GDRs when sent to him. The Medical Director expected that if there was no response to the second request that he be contacted so he could consult with the attending physician to try and resolve the lack of response. The Medical Director stated it was usually the Director of Nursing who let him know if there is an issue. During an interview on 1/5/24 at 12:51 PM, the Director of Nursing revealed that when GDRs were given to her, she would take them to the NP who worked with the MD so they could be addressed right away. The DON was not aware that the attending physician for Resident #38 had not been responding to the Pharmacist's GDR request. The DON stated she expected staff to notify her if a GDR request was not address within 24 hours so she could notify the Medical Director to help work with the attending physician to get a response and a progress note related to the GDRs.	F 756	6. Date of Compliance: 1/20/2024	

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F 756	Continued From page 36 During an interview on 1/5/24 at 4:28 PM, the Administrator revealed he was unaware a pharmacy recommendation dated 08/08/23, 09/06/23, and 11/03/23 had not been addressed for Resident #38. His expectations were that if the attending physician does not respond to recommendations, the nursing department should have brought it to his and the Medical Director attention.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record review the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 medication errors out of 32 opportunities (Resident #51). The findings included: (1a) Physician orders for Resident #51 were noted for Refresh eye drops, 1 drop in both eyes twice a day. The Medication Administration Record (MAR) showed Refresh eye drops 1 drop in both eyes BID at 8:00AM and 8:00PM. An observation was conducted on 1/4/24 at 8:20 AM of Medication Aide (MA) #1 administering medication on the 100 hall. MA #1 was observed placing two drops of Refresh eye drops in both	F 759	F759: Free of Medication Errors: 1. Residents #51 continues to receive medications per physician□s orders. There were no negative outcomes identified resulting from these observations. 2. On 1/19/2024, the administrator audited the medication error log and monthly consultant pharmacy reports from 10/1/2023 to 1/19/2024. There were no other identified medication errors. There were no negative outcomes identified as a result of this audit. 3. Beginning on 01/05/2024, 100% of nurses and medication aides were educated by the Assistant Director of	1/20/24

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F 759	Continued From page 37 eyes. On 1/4/24 at 11:14 AM an interview was conducted with MA #1. After reviewing the orders for Refresh eye drops MA #1 reported she thought that it was two drops per eye for the refresh drops. (1b) Physician orders for Resident #51 revealed Fiber Gummies 1 gummy by mouth twice a day. The MAR showed 1 Fiber Gummy by mouth twice a day at 8:00AM and 8:00PM. An observation was conducted on 1/4/24 at 8:22 AM MA #1 was observed signing the medication administration record that two fiber gummies were administered. The fiber gummies were not assessed as being in the medication cup by the surveyor when MA#1 took the cup of medications to Resident #51. A later review of the Medication Administration record (MAR) revealed that the fiber had been signed as given. During the interview on 01/04/24 at 11:14 AM with MA #1 concerning the fiber gummies, MA # 1 stated she did not mean to sign off medication due to not having the medication available at the time of medication pass. On 1/5/24 at 12:51 PM, an interview was conducted with the Director of Nursing. During the interview, she was notified of the medication error rate of 6.25%. She stated she was aware of the two medication errors since the employee had reported it to her. The interview revealed the Director of Nursing expectations for medication pass was that all nurses or medication aids use the five rights of medication pass, and if a medication error occurs, they report them to her	F 759	Nursing (ADON) on the facility policy for Medication Administration. The education included following physician orders for medication administration. The education was complete by 1/19/2024. Any newly hired nurses or medication aides beginning after 1/19/2024 will receive this education from the ADON or trained designee during orientation and training prior to working the floor. 4. Beginning on 1/19/2024, medication audits will be conducted by the DON or trained designee to ensure compliance with F759. Variances will be corrected at the time of audit and additional education provided as indicated. The audits will be conducted at the following frequency: i. 15 residents□ medication administrations per week for 4 weeks; ii. 10 residents□ medication administrations per for 4 weeks; iii. 5 residents□ medication administrations per week for 4 weeks. 5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F759. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F759. 6. Date of Compliance: 1/20/2024	

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F 759	Continued From page 38 immediately so corrections could be made.	F 759		
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 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 interviews the facility failed to secure medications stored at the bedside for 3 of 3 residents (Resident #20, Resident #42, and Resident #8) reviewed for medication storage. Findings included:	F 761	F761: Label/Storage of Drugs/Biologicals: 1. Medications located in rooms for residents #42, #8, and #20 were removed at the time of observation. No negative outcomes were identified as a result of these observations.	1/20/24

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F 761	Continued From page 39 1. Resident #20 was admitted to the facility on 12/05/20 with diagnoses including chronic obstructive pulmonary disease (abbreviated as COPD and meaning a group of lung diseases that block airflow and make breathing difficult) and pneumonia. Review of Resident #20's Physician orders revealed an order dated 11/25/23 for budesonide-formoterol fumarate (a long-acting medication that opens the airways) 2 puffs once a day for COPD. The quarterly Minimum Data Set (MDS) assessment dated 12/04/23 revealed Resident #20 was cognitively intact and used oxygen. During an observation and interview with Resident #20 on 01/04/24 at 8:22 AM an inhaler containing budesonide-formoterol fumarate was sitting in clear view on the resident's overbed table. Resident #20 stated the inhaler on her overbed table was her rescue inhaler that she only used when she needed it for shortness of breath, and she could not recall the last time she used the inhaler. An interview with the Director of Nursing (DON) on 01/04/24 at 10:25 AM revealed Resident #20 had not been assessed to self-administer medication and the inhaler should not have been left in her room. She explained unless a resident had been assessed as safe to self-administer medication and had a Physician order to leave medication in the room, medication should be stored in the medication cart. 2. Resident #42 was admitted to the facility	F 761	2. Between 1/17/2024 and 1/19/2024, all resident rooms were audited by the IDT team to ensure there were no medications in rooms of residents that had not been assessed to safely keep them. Variances were corrected at the time of audit. There were no negative outcomes identified resulting from this audit. The Administrator completed the CMS-20089 Medication Storage surveyor pathways audit on 1/17/2024. There were no deficiencies found. 3. Beginning on 01/05/2024, 100% of nurses and medication aides were educated by the ADON on the facility policy for Medication Administration. The education included self administration evaluations for residents. The education was complete by 1/19/2024. Any newly hired nurses or medication aides beginning after 1/19/2024 will receive this education from the Assistant Director of Nursing (ADON) or trained designee during orientation and training prior to working the floor. 4. Beginning 1/19/2024, the administrator or trained designee will audit rooms for proper storage and labeling of drugs and biologicals. Variances will be corrected at the time of audit and additional education provided as indicated. The audits will be conducted at the following frequency: a. 15 rooms per week for 4 weeks; b. 10 rooms per week for 4 weeks; c. 5 rooms per week for 4 weeks.	

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F 761	Continued From page 40 05/31/21 with diagnoses including diabetes and non-Alzheimer's dementia. Review of Resident #42's Physician orders revealed an order dated 12/08/23 to apply zinc oxide every shift to her inner buttocks. The quarterly Minimum Data Set (MDS) assessment dated 12/29/23 revealed Resident #42 was severely cognitively impaired. An observation of Resident #42's overbed table on 01/04/24 at 8:22 AM revealed a medication cup of grayish/white cream sitting on top of the table. An interview with Medication Aide (MA) #10 on 01/04/23 at 8:32 AM revealed she began her shift at 7:00 AM and had not yet been in Resident #42's room, so she was not aware it was sitting on her overbed table and was not sure what type of cream was in the cup. An interview with the Director of Nursing (DON) on 01/04/24 at 10:25 AM revealed no creams should be left at the resident's bedside unless they had been assessed to self-administer medication. She confirmed Resident #42 had not been assessed for medication self-administration and her medication should be stored in the medication/treatment cart. The DON stated she was not sure what type of cream was in the medication cup in Resident #42's room. An interview with Nurse #11 on 01/05/24 at 1:01 PM revealed she worked the 7:00 PM to 7:00 AM shift on 01/03/24 and was assigned to care for Resident #42. She stated she dispensed zinc cream (she wasn't sure of the strength) from the	F 761	5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F761. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F761. 6. Date of Compliance: 1/20/2024	

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F 761	Continued From page 41	F 761		

medication/treatment card and gave it to a nurse aide (NA) to apply to Resident #42's bottom. Nurse #11 confirmed she did not follow-up with the NA to confirm the cream was applied to Resident #42.

3. Resident #8 was admitted to the facility 09/01/19 with diagnoses including diabetes and anemia.

Review of Resident #8's Physician orders revealed an order dated 11/02/23 to apply house stock zinc oxide for prevention every shift.

The quarterly Minimum Data Set (MDS) assessment dated 11/25/23 revealed Resident #8 was cognitively intact.

An observation and interview with Resident #8 on 01/04/23 at 8:02 AM revealed a medication cup containing a grayish/white cream sitting on the dresser by his bed. Resident #8 stated staff applied the cream to his bottom two or three times a day, but the cup on his dresser had been there "since last night".

An interview with Medication Aide (MA) #10 on 01/04/24 at 8:07 AM revealed she began her shift at 7:00 AM and had not yet been in Resident #8's room, so she was not aware it was sitting on his dresser and was not sure what type of cream was in the cup.

An interview with the Director of Nursing (DON) on 01/04/24 at 10:25 AM revealed no creams should be left at the resident's bedside unless they had been assessed to self-administer medication. She confirmed Resident #8 had not been assessed for medication self-administration

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F 761	Continued From page 42 and his medication should be stored in the medication/treatment cart. The DON stated she was not sure what type of cream was in the medication cup in Resident #8's room. An interview with Nurse #11 on 01/05/24 at 1:01 PM revealed she worked the 7:00 PM to 7:00 AM shift on 01/03/24 and was assigned to care for Resident #8. She stated she dispensed zinc cream (she wasn't sure of the strength) from the medication/treatment card and gave it to a nurse aide (NA) to apply to Resident #8's bottom. Nurse #11 confirmed she did not follow-up with the NA to confirm the cream was applied to Resident #8.	F 761		
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. §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	F 842		1/20/24

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F 842	Continued From page 43	F 842		

§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 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

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F 842	Continued From page 44 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 record review and staff interviews, the facility failed to ensure a medication administration record was accurate (Resident #51) and failed to maintain complete and accurate medical records by not documenting a resident's discharge to the community Against Medical Advice (Resident #90) and a resident's transfer to the hospital (Resident #95) for 3 of 6 sampled residents reviewed for medication pass and closed record review. Findings included: 1. Resident #51 was admitted to the facility on 12/14/22. An observation was conducted on 1/4/24 at 8:22 AM. MA #1 was observed signing the medication administration record that two fiber gummies were administered. The fiber gummies were not in the medication cup that MA#1 took to Resident #51. Review of Resident #51's medication administrated record (MAR) revealed that Medication Aid (MA) #1 had signed off as giving Resident #51 two fiber gummies during a medication pass observation on 1/4/24. During the interview on 01/04/24 at 11:14 AM with MA #1 concerning the fiber gummies, MA # 1 stated she did not mean to sign off the	F 842	F842: Resident Records: 1. Resident #90 was discharged on 10/21/2023, prior to annual survey. No negative outcome was identified as a result of this observation. Resident #95 was discharged on 11/06/2023, prior to annual survey. No negative outcomes was identified as a result of this observation. Resident #51 continues to have medication administration documented in the medical record per facility policy. No negative outcomes was identified as a result of this observation. 2. On 1/19/2024, the administrator conducted an audit of medical records, specifically MARs and discharge documentation, spanning from the previous 90 days to current to ensure that medical records were accurate. Variances, as applicable, were corrected at the time of audit. There were no negative outcomes identified as a result of this audit. 3. 100% of licensed nurses and medication aides were inserviced by the Assistant Director of Nursing (ADON) between 1.5.24 and 1.19.24 on the facility	

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F 842	Continued From page 45 medication due to not having the medication available at the time of medication pass. MA stated she should not have signed off the medication until it had been given. On 1/5/24 at 12:51 PM, an interview was conducted with the Director of Nursing stating that no medication should be signed off until administered to the resident. 2. Resident #90 was admitted to the facility on 10/16/23. The discharge Minimum Data Set (MDS) assessment dated 10/21/23 indicated Resident #90 discharged to the community with return not anticipated. Review of Resident #90's medical record revealed a scanned copy of a Discharge AMA Form dated 10/21/23 that was signed by Resident #90, his family member and Nurse #5. Review of the staff progress notes revealed no entry on or after 10/21/23 describing the events of Resident #90 discharging to the community AMA. Telephone attempts on 01/03/24 at 2:29 PM and 01/04/24 at 10:53 PM for an interview with Nurse #5 were unsuccessful. During an interview on 01/04/24 at 3:57 PM, the Assistant Director of Nursing (ADON) reviewed Resident #90's medical record and confirmed there was no staff progress note detailing the events of Resident #90's discharge on 10/21/23. The ADON explained when a resident discharged from the facility, normally they completed a recapitulation (summary) of the resident's stay	F 842	policies for Documentation Expectations, Transfer and Discharge Requirements, and Medication Administration. Newly hired nurses and medication aides that are hired after 1.19.24 will receive this education by the ADON or trained designee during orientation and training prior to working the floor. 4. Beginning after 1/19/2024, the Director of Nursing (DON) or trained designee will audit medical records for all residents that discharge from the to ensure the residents have a complete and accurate medical record. Variances will be corrected at the time of audit and additional education provided as indicated. The audit period will be 90 days. Beginning after 1/19/2024, medication administration audits will be conducted by the DON or trained designee to ensure compliance with F842. The audit will be during the resident's medication pass and ensure that the EMR was accurately documented. Variances will be corrected at the time of audit and additional education provided as indicated. The audits will be conducted at the following frequency: i. 15 residents□ medication administrations per week for 4 weeks; ii. 10 residents□ medication administrations per for 4 weeks; iii. 5 residents□ medication administrations per week for 4 weeks.	

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F 842	Continued From page 46 but one wasn't done since Resident #90 decided to leave AMA. The ADON stated Resident #90's discharge should have been documented by Nurse #5 in a staff progress note and was not sure why one wasn't done. During an interview on 01/05/24 at 1:18 PM, the Director of Nursing stated when Resident #90 discharged from the facility AMA on 10/21/23, she would have expected for the nurse to have documented a progress note that included details such as the reason for Resident #90's discharge, what time he left the facility, his condition at the time of discharge, and any prescriptions and/or paperwork he was provided. 3. Resident #95 was admitted to the facility on 10/24/23. The discharge Minimum Data Set (MDS) assessment dated 11/06/23 indicated Resident #95 discharged to the hospital with return not anticipated. Review of the staff progress notes revealed the last documented progress note was an entry dated 11/06/23 at 9:30 AM written by the Assistant Director of Nursing (ADON). The progress note read in part, Resident #95's family is reporting Resident #95 ran a low-grade temperature over the weekend of 100 degrees and are requesting a urinalysis due to discoloration of her urine and increased confusion. Resident #95 is currently on Augmentin (antibiotic medication) due to cholecystitis (inflammation of the gallbladder). The ADON noted she would inform the medical provider of the family's concerns. There was no entry indicating Resident #95 was transferred to	F 842	5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F842. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F842. 6. Date of Compliance: 1/19/2024	

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F 842	Continued From page 47 the hospital. During an interview on 01/05/24 at 9:24 AM, the ADON explained on 11/06/23 after she had talked with Resident #95's family and informed the medical provider of their concerns, Resident #95's family went to the Director of Nursing (DON) stating Resident #95 needed to go to the hospital and they had already called Emergency Medical Services (EMS) for transport. The ADON couldn't recall the exact time but stated EMS arrived at the facility within minutes of the family informing the DON. The ADON stated she should have documented a progress note when Resident #95 was transported to the hospital at the family's request. During an interview on 01/05/24 at 1:19 PM, the DON explained Resident #95's family called EMS on 11/06/23 to transport her to the hospital and staff were not aware until EMS arrived at the facility. The DON stated she would have expected for the nurse to have documented a progress note indicating Resident #95 was sent to the hospital via EMS at the family's request.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		1/20/24

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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.

§483.75(d)(2) The facility will develop and

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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 assessment required at §483.70(e).
Improvement projects must include at least

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F 867	Continued From page 50 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, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 06/22/22, complaint investigation survey completed on 08/01/23, and the complaint investigation survey completed on 11/20/23. This was for three repeat deficiencies: one in the area of infection control originally cited on 06/22/22 during a recertification survey, one in the area of resident records-identifiable information originally cited on 06/22/22 during the recertification survey, and one in the area of residents right to self-administer medications originally cited on	F 867	F867: QAPI/QAA Improvement Activities: 1. The facility will continue to ensure that the quality assessment and assurance committee meets at least monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. No negative outcomes were identified as a result of these observations. The Administrator and IDT team conducted the QAPI Self Assessment Tool from the CMS website on 1/15/2024.	

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F 867	Continued From page 51 08/01/23 during a complaint investigation survey. In addition, the deficiency in the area of resident records-identifiable information was recited on 11/20/23 during a complaint investigation survey. All three deficiencies were subsequently recited on 01/05/24 during the recertification, follow-up and complaint investigation survey. The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F554: Based on observations, record review, resident and staff interviews, the facility failed to assess residents to determine if self-administration of medication was clinically appropriate for a resident who wanted to self-administer over-the-counter lubricating eye drops and had a physician order indicating the eye drops may be left at bedside and a resident observed with medicated creams left on a shelf in the resident's room for 2 of 3 sampled residents (Resident #66 and #55). During the complaint investigation of 08/01/23, the facility failed to assess the ability of a resident to self-administer medications observed with medications at bedside. F842: Based on record review and staff interviews, the facility failed to ensure a medication administration record was accurate (Resident #51) and failed to maintain complete and accurate medical records by not documenting a resident's discharge to the	F 867	2. All residents have the potential to be affected by deficiencies related to F867. The facility is currently working a plan of correction for the repeated citations (F554, F842, and F880), as listed in this document. No negative outcomes were identified as a result of these observations. A root cause analysis was conducted on 1/15/2024 by the Administrator and IDT team for each of the repeated citations (F554, F842, and F880) as well as regarding the QAPI process. 3. On 1/10/2024, the Administrator was educated by the corporate office's chief nursing team on Assurance and Performance Improvement QAPI. On 1/11/2024, the Administrator reached out to the state designated Quality Improvement Organization (QIO) to discuss QAPI citation and plan of corrections for state survey. On 1/16/2024, the Administrator educated the IDT team on QAPI expectations and the recommended audit calendar to audit multiple areas of practice in the facility throughout the calendar year. The Administrator assigned audits to be completed monthly and some less frequent (such as quarterly). The potential citations from the annual survey and plans of corrections to fix deficient practices were also discussed. The policy Quality Assurance Performance Improvement	

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F 867	Continued From page 52 community Against Medical Advice (Resident #90) and a resident's transfer to the hospital (Resident #95) for 3 of 6 sampled residents reviewed for medication pass and closed record review. During the recertification survey of 06/22/22, the facility failed to maintain an accurate Treatment Administration Record (TAR) for checking the placement of a left-hand splint. During the complaint investigation of 11/20/23, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of vaginal cream. F880: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies and procedures when Nurse Aide (NA #3) did not handle soiled linen in a sanitary manner and did not perform hand hygiene after removing gloves for 1 of 1 room (room 114) observed for infection control. During the recertification survey of 06/22/22, the facility failed to follow the Center of Disease Prevention and Control (CDC) recommended guidance for personal protective equipment (PPE) usage for new admission residents who were not fully vaccinated when staff members were observed entering resident rooms with signage posted that indicated Contact Droplet Precautions without the use of a gown, gloves, or an N-95 respirator mask to deliver meal trays. During an interview on 01/05/24 at 4:43 PM, the Administrator revealed he had only been employed at the facility since the end of November 2023 and it was hard for him to say	F 867	Committee was utilized. Any newly hired members of the IDT team after 1/19/24 will be educated by the Administrator during orientation and training prior to working the floor. On 1/17/2024, the Administrator met with the state designated QIO to discuss citations and receive expert opinion on successful plans of correction. This call will initiate the relationship with the QIO in regard to this survey, and the facility will work with the QIO until substantial compliance with the QAPI Committee is received. 4. Continuing from 12/16/2023, the Regional Quality Assurance Nurse will review the facility's quality assurance action plans monthly for the next 3 months then randomly thereafter to ensure continued compliance. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator. The tool will include that the facility has discussed all areas of the citations from the survey (F554, F842, and F880) to ensure that the QAPI team has appropriate plans in place and discussions/recommendations regarding any deficient practices. The Regional Clinical Coordinator will attend the facility quality assurance meeting monthly x 3 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated. Continued compliance will be	

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F 867	Continued From page 53 where the breakdown occurred regarding the repeat deficiencies but felt it was likely due to having an all-new nursing administration team. The Administrator explained the QA committee met monthly to discuss various topics and if needed, develop strategies to put into place for improvement. The Administrator stated the QA committee would be reviewing and discussing the areas of concern identified during the current survey and with the strong and cohesive administration team he now had, he was confident they would be able to ensure monitoring was done so that going forward, compliance was achieved and maintained.	F 867	monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. 5. The audits from the repeated citations are included in this plan for citations F554, F842, and F880. These citations, plus compliance with F867, will be monitored monthly beginning 1/16/2024 by the facility's QAPI committee for at least 3 more months, or longer if deemed appropriate by the QAPI Committee. 6. Date of Compliance: 1/20/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		1/20/24

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 55 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies and procedures when Nurse Aide (NA #3) did not handle soiled linen in a sanitary manner and did not perform hand hygiene after removing gloves for 1 of 1 room (room 114) observed for infection control. Findings included: Review of the facility's policy titled "Laundry Services" last revised 10/17/23 read in part as follows: "Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. Standard precautions will be used by clinical staff handling linen. All soiled linen should be bagged or put into carts at the location where used." Review of the facility's policy titled "Hand Hygiene" last revised 10/11/23 read in part as follows: "Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections. Hand hygiene should be performed after removing personal protective equipment (e.g. gloves)." A continuous observation of Nurse Aide (NA) #3	F 880	F880: Infection Prevention and Control: 1. The facility will continue to provide appropriate laundry services, hand hygiene, and multi-route transmission based precautions per facility policies. There were no negative outcomes identified resulting from these observations. 2. All residents have the possibility to be affected by deficiencies related to F880. On 1/18/2024, the Administrator completed the Environmental Rounds Worksheet for Infection Prevention. Variances were corrected at the time of observation. There were no negative outcomes identified resulting from these observations. 3. Beginning on 1/5/2024, 100% of staff were educated on infection control and prevention by the Assistant Director of Nursing (ADON)/Infection Preventionist. The education included the policies: Laundry Services, Hand Hygiene Policy, and Multi-Route Transmission Based Precautions. The education was completed by 1/19/2024. Any new hires after 1/19/2024 will be educated on the	

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F 880	Continued From page 56 on 01/03/24 from 12:10 PM through 12:13 PM revealed she carried un-bagged, used linen from room 114 (at the end of the hall) to the soiled linen bin at the top of the hall with gloved hands. She did not carry the linen close to her body. NA #3 placed the linen in the soiled linen bin and began walking back down the hallway with gloved hands. NA #3 stopped midway in the hall, removed her gloves, discarded them in a trash can, and began pushing Resident #51 up the hall in her wheelchair. She did not perform hand hygiene after removing her gloves and before touching Resident #51's wheelchair. An interview with NA #3 on 01/03/24 at 2:03 PM revealed she changed the bed linen in room 114 and was aware that all linen removed from a resident room should be bagged and soiled gloves should be discarded before leaving the resident's room. She stated she just got in a hurry when she carried the linen out of room 114 without a bag. NA #3 stated she thought she performed hand hygiene after removing her gloves and before touching Resident #51's wheelchair. An interview with the Assistant Director of Nursing (ADON)/Infection Preventionist on 01/04/24 at 3:34 PM revealed all linen should be bagged and gloves should be removed before exiting the resident's room. She stated hand hygiene should be performed after removing gloves and before touching other surfaces. An interview with the Director of Nursing (DON) on 01/05/24 at 1:29 PM revealed all linen should be bagged and gloves should be removed before exiting the resident's room. She stated hand hygiene should be performed after gloves were	F 880	same policies and procedures during orientation by the ADON or designee prior to working the floor. 4. Beginning on 1/19/2024, the ADON or trained designee will complete infection control walking rounds. Variances will be corrected at the time of observation and additional education provided as indicated. The rounds will be conducted at the following frequency: a. 5 days per week for 4 weeks; b. 3 days per week for 4 weeks; c. 1 day per week for 4 weeks. 5. The QAPI team will meet monthly for 3 months or until resolved to discuss compliance with the plan to remain in compliance with F880. The Administrator will bring all info from the plan of correction to the QAPI meeting each month. The QAPI team will discuss the ongoing plan of corrections as well as monitoring and auditing frequencies in order to continue to meet the standards associated with F880. 6. Date of Compliance: 1/20/2024	

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F 880	Continued From page 57 removed and before touching other items.	F 880		