| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345534 | A. BUILDING _____ B. WING _____ | C 01/24/2024 |

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| SANFORD HEALTH & REHABILITATION CO | 2702 FARRELL ROAD SANFORD, NC 27330 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint survey were conducted on 1/21/24 through 1/24/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# QJOR11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey were conducted from 1/21/24 through 1/24/24. Event ID# QJOR11. The following intakes were investigated NC00200893, NC00200788, NC00205099, NC00205142, NC00207165, NC00198942, NC00203647, NC00207474, NC00208638 and NC00205433.<br>1 of the 20 complaint allegations resulted in deficiency. | F 000 | | |
| F 694 SS=D | Parenteral/IV Fluids<br>CFR(s): 483.25(h)<br><br>§ 483.25(h) Parenteral Fluids.<br>Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff, resident, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility failed to obtain Physician orders for the care and maintenance of a peripherally inserted central catheter(PICC) intravenous line for 1 (Resident #33) of 1 residents reviewed for intravenous (IV) therapy. The findings included:<br><br>Resident #33 was originally admitted on 11/22/23 | F 694 | On 1/23/2024, resident #33 had a PICC line in place with no current order to flush PICC line. Nurse # 1 stated she had been flushing resident #33□s PICC line using the SASH method (saline, administration of medication, saline, then Heparin). On 1/23/2024 an order to flush resident # 33□s PICC line with 10 cubic centimeters (cc□s) of Normal Saline pre and post medication administration was entered. | 2/2/24 |

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

Electronically Signed | 02/05/2024

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| F 694 | Continued From page 1<br>with a diagnosis of Methicillin-resistant Staphylococcus Aureus (MRSA) infection following a right total knee replacement (TKA).<br><br>Review of Resident #33's admission Minimum Data Set (MDS) dated 11/29/23 indicated she was cognitively intact and not coded for the use of an antibiotic (medication prescribed to treat bacterial infections).<br><br>Review of Resident #33 electronic medical record (EMR) indicated she transferred to the hospital on 1/8/24 for scheduled knee procedure. She was readmitted on 1/12/24 with orders for an IV antibiotic.<br><br>Resident #33 was care planned on 1/15/24 for the use of a PICC line. Interventions included to flush her PICC line per facility protocol.<br><br>Review of Resident #33's January 2024 Physician orders did not include an order for the flushing of her PICC line.<br><br>An observation and interview was completed with Resident #33 on 1/21/24 at 1:12 PM. Observed in her room was an IV pump with an empty medication bag and tubing from earlier IV medication on 1/21/24. The dressing to her PICC line was dated 1/18/24. Resident #33 stated she would be on IV antibiotic for a while due to a "staph" infection in her knee.<br><br>An interview was completed on 1/23/24 at 11:30 AM with Nurse #1. She was asked to review Resident #33's January Physician orders to see if there were orders for flushing her PICC line. Nurse #1 verified there were no Physician orders for flushing the PICC line and stated she had | F 694 | Added order for IV PICC line tubing changes every 24 hours for resident # 33 and changing IV cap every 24 hours. On 1/23/2024, all residents had standing orders entered for flush pic line with 10 ml of normal saline before and after each administration, PICC line tubing changes every 24 hours and changing IV cap every 24 hours. All new admissions will have standing orders entered for PICC line flush upon admission.<br><br>On 1/23/2024, 100% of residents with PICC lines were identified by Director of Nursing to ensure any resident who had a PICC line had an order to flush PICC line. Any resident with a PICC line that did not have a flush order were corrected immediately. No other issues were identified in the audit.<br><br>On 1/23/2024, the Director of Nursing initiated an in-service for all Licensed Nurses and Medication Aides for PICC line flush orders. This in-service was completed on 1/23/2024, any staff who did not receive the in-service will not be allowed to work until complete. This will be added to the new hire orientation.<br><br>The Director of Nursing or designee will audit 5 residents 3x weekly x 4 weeks for PICC line flush orders, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be | |

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| F 694 | Continued From page 2<br>been flushing Resident #33's PICC line using the SASH method (saline, administration of medication, saline then Heparin-(blood thinner)).<br><br>Review of a new Physician order dated 1/23/24 read to flush Resident #33's PICC line with 10 cubic centimeters (cc's) of Normal Saline pre and post medication administration.<br><br>A telephone interview was completed on 1/23/24 at 2:00 PM with the NP. He stated he was at the facility earlier and apparently the facility discovered earlier that there were no orders on how to flush Resident #33's. PICC line. He stated the use of Heparin would not have resulted in harm to Resident #33 but the facility should be flushing her PICC line at minimum using 10cc's of Normal Saline pre and post administration of the medication.<br><br>An observation and interview was completed on 1/24/24 at 9:30 AM with Nurse #2. She was observed flushing Resident #33's PICC line with 10cc's of Normal Saline followed by the medication then flushed again with another 10cc's of Normal Saline. She stated she followed the Physician order that was entered yesterday on 1/23/24.<br><br>An interview was completed with the MD on 1/24/24 at 9:45 AM. She stated there should always be specific Physician orders on the flushing of a PICC line.<br><br>An interview was completed with the Director of Nursing (DON) on 1/24/24 1:25 PM. He stated there should have been a Physician order regarding the flushing of Resident #33's PICC line. | F 694 | made if further monitoring is necessary.<br><br>Date of Compliance: 2/2/2024 | |

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| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff and Medical Director interviews, the facility failed to obtain Physician orders for continuous oxygen (Resident #73). This was for 1 of 2 residents reviewed for respiratory care.<br><br>The findings included:<br><br>Resident #73 was admitted to the facility on 04/24/23 with diagnosis that included gastrointestinal hemorrhage, hypertension, and peripheral vascular disease.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 01/09/2024 indicated Resident #18 was cognitively intact and was not coded for receiving oxygen therapy.<br><br>Review of Resident #73's nursing progress notes dated 01/11/24 revealed Resident #73 was sent to the emergency room (ER) due to vomiting. She returned to the facility on 2L of oxygen (O2) via nasal cannula. The O2 was removed during transfer to the bed from the wheelchair causing her O2 saturation to drop to 86%. O2 was reapplied via nasal cannula raising her O2 sats to | F 695 | On 1/22/2024, Resident #73 had oxygen applied with no current oxygen order. On 1/22/24 an O2 order was entered by the Director of Nursing. On 1/22/2024, all residents had standing orders entered for “oxygen 2 liters per minute via nasal canula prn check Spo2 and titrate to keep above 92% notify MD when oxygen is initiated.” All new admissions will have standing orders entered for oxygen upon admission.<br><br>On 1/22/2024, 100% of all in-house residents were visualized by the nursing administration team to ensure any resident who required oxygen had an order for oxygen. Any resident with oxygen that did not have an order were corrected immediately. No other issues were identified in the audit.<br><br>On 1/22/2024, the Staff Development Coordinator initiated an in-service for all Licensed Nurses and Medication Aides for oxygen use orders. This in-service was completed on 1/22/2024, any staff who did | 2/2/24 |

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| F 695 | Continued From page 4<br>95% on 2L.<br><br>Review of Resident #73's nursing progress notes dated 01/12/24 revealed no new orders were received for treatment related to her emergency room visit on 01/11/24.<br><br>Resident #73's active care plan, last reviewed 01/15/24, included a focus for oxygen (O2) therapy as needed to maintain 02 saturations of 90% or greater. The interventions included administering oxygen as ordered and encouraging the resident to wear oxygen as ordered.<br><br>A review of Resident #73's December 2023 and January 2024 physician orders did not include an order for oxygen.<br><br>During an observation and interview 01/21/24 at 11:51 AM, Resident #73 was lying in bed with oxygen running at 1 ½ liters (L)/minute (min) flow via concentrator. She indicated she used oxygen all the time.<br><br>In an observation on 01/21/24 at 2:51 PM, Resident #73 was lying in bed with oxygen running at 1 ½ liters (L)/minute (min) flow via concentrator.<br><br>In an observation on 01/22/24 at 8:38 AM, Resident #73 was lying in bed with oxygen running at 1 ½ liters (L)/minute (min) flow via concentrator.<br><br>An interview was conducted with Unit Manager #1 on 01/22/24 at 2:36 PM. She verified that Resident #73 did not have an active order for oxygen (O2). She stated the resident recently | F 695 | not receive the in-service will not be allowed to work until complete. This will be added to the New Hire education.<br><br>The Director of Nursing or designee will audit 5 residents 3x weekly x 4 weeks for oxygen orders, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be made if further monitoring is necessary.<br><br>Date of Compliance: 2/2/2024 | |

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| F 695 | Continued From page 5<br>returned from the hospital and returned with no new orders. She indicated when residents returned from the hospital with O2 without an order they would initiate the order and notify the physician.<br><br>A phone interview was conducted with Nurse #2 on 01/22/24 at 4:54 PM. She verified that Resident #73 returned to the facility on 01/11/24 on 2L of oxygen (O2) via nasal cannula. It was an oversight that an order for O2 was not added to her active orders.<br><br>An interview was conducted with the Director of Nursing (DON) on 01/23/24 at 3:20 PM. He stated anyone that received oxygen (O2) should have an active order in place.<br><br>An interview was conducted with the Medical Director (MD) on 01/24/24 at 9:55 AM. She stated anyone that received oxygen (O2) should have an order in place. She indicated she was not aware oxygen had been placed on Resident #73. | F 695 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, | F 755 | | 2/2/24 |

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| F 755 | Continued From page 6<br>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to secure unused narcotic medications for disposition (the process of returning unused medications) resulting in possible diversion (the transfer of a controlled medication from a lawful to an unlawful channel of distribution or use). This was for 1 of 1 discharged resident (Resident #92) reviewed for pharmacy services.<br><br>The finding included:<br><br>Resident #92 was admitted to the facility on 04/25/23 and expired on 08/24/23.<br><br>Review of Resident #92 ' s physician orders revealed an order initiated on 06/02/23 and discontinued on 08/10/23 for oxycodone 5 | F 755 | The facility failed to secure unused narcotic medications for disposition on 8/20/2023. On 8/20/2023 a bubble pack containing 16 oxycodone 5 mg tablets and the narcotic sheet went missing, while the door to the medication room on 100 hall was left propped open.<br><br>On 8/20/2023 implementation of locked boxes in both medication rooms were initiated with key access only by limited staff to include DON and designee. Only DON and designee can send narcotics back. Audit consisted of narcotic sheets verified against actual cards on all carts on 8/20/2023. No further issues identified in the audit. | |

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| F 755 | Continued From page 7<br>milligrams (mg) tablet, take one tablet by mouth every 8 hours as needed for moderate pain.<br><br>An attempt to interview the Weekend Supervisor was made on 01/23/24 at 1:02 PM without success.<br><br>Weekend Supervisor ' s statement revealed he reported on 08/20/23 about 5:30 AM the door to the medication room on 100 hall was propped open. When he entered the room, the pharmacy tote's secure tags (tags applied to both ends of the tote to secure it shut) were cut and sitting on top of the tote. The Weekend Supervisor reported that on 08/19/23 he and another nurse had written up medications to be returned to the pharmacy to include non-narcotics and narcotics. They placed them into the pharmacy tote and applied the secure tags for return to the pharmacy. Upon further review of the tote, it was noted that the narcotic sheet that was previously in the tote was missing along with the bubble pack containing 16 Oxycodone 5mg tabs.<br><br>A phone interview was conducted with the Staff Development Nurse on 01/23/24 at 1:24 PM. She stated she was made aware of missing narcotic medications at the facility on 08/20/23 between 5:30 and 6:00 AM by the weekend supervisor. She indicated he stated that at about 5:30 AM he seen that the door to the medication room on 100 hall was propped open. When he entered the room, the blue pharmacy tote's secure tags were cut and sitting on top of the tote and the narcotic sheet that was previously in the tote was missing along with the bubble pack containing 16 oxycodone 5mg tablets. She then stated she arrived at the facility on 08/20/23 between 8:00 and 9:00 AM to start her investigation for possible | F 755 | On 1/24/2024 the Director of Nursing and Unit Managers initiated education to all Licensed Nurses and Medication Aides on ensuring medication room doors are closed and locked at all times, and medication room doors are not propped open at any point. Narcotics must remain on the cart until they are pulled by the Director of Nursing or the night supervisor. This in-service was completed on 1/24/2024, any staff who did not receive the in-service will not be allowed to work until complete. This will be added to the New Hire Orientation education.<br><br>The Director of Nursing or designee will audit med room to ensure it is locked daily and that there are no narcs in blue totes weekly x 4 weeks, then 3x weekly for 4 weeks, then 1x weekly for 4 weeks. All narcotic count sheets will be checked and accounted for on each cart 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks. The Director of Nursing will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be made if further monitoring is necessary.<br><br>Date of Compliance: 2/2/2024 | |

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| F 755 | Continued From page 8<br>diversion of narcotic medications. She further stated she notified law enforcement, and they came to the facility to take the report. She also indicated she did not remember who she interviewed during her investigation.<br><br>During an interview with the Director of Nursing (DON) on 01/23/24 at 3:20 PM he explained that he returned to work on 08/21/23 from a bereavement time off period. He indicated he completed the possible narcotic medication diversion investigation. He stated he located the missing narcotic sheet along with the empty narcotic bubble pack medication card in a shred box in the 100 hall locked nourishment room. All 16 oxycodone tablets had been removed from the bubble pack. He also indicated although the medication room door had been sticking at times the door should not have been propped open for any reason and all medications should be secured at all times. | F 755 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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 | F 761 | | 2/2/24 |

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| F 761 | Continued From page 9<br>personnel to have access to the keys.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to label multi-dose medications with the date they were opened on 1 of 3 medication carts reviewed (the 300 Hall Medication Cart).<br><br>Findings included:<br><br>An observation was conducted on 01/21/24 at 3:25 PM of the nurse ' s medication cart on the 300 Hall in the presence of Med Aide #1 and Unit Manager #1. The observation revealed no opened date on the following multi-dose medications:<br><br>a. Two 10ml (milliliter) multi-dose vials of Humalog insulin with no open date. (Manufacturer ' s recommendation to discard 28 days after opening).<br><br>first use<br><br>b. two 10ml (milliliter) multi-dose vial of Novolog insulin with no open date. (Manufacturer ' s recommendation to discard 28 days after opening). | F 761 | On 01/21/2024 an observation was conducted of the nurse's medication cart on 300 Hall. The observation revealed no opened date on two multidose vials of Humalog insulin, two multi-dose vials of Novolog, one multi-dose package of inhalation vials and one multi-dose bottle of eye drops. The unit manager removed the open undated items immediately from the cart.<br><br>On 01/21/2024, the administration nurses audited all medication carts and medication rooms for any undated, unrefrigerated, or expired medications and discarded such items. No further issues were identified in the audit.<br><br>On 01/21/2024 the Director of Nursing and Unit Managers initiated education to all Licensed Nurses and Medication Aides on dating medications when opened and checking expiration date of medications. All licensed nurses or medication aides completed the education by 01/25/2024 | |

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| F 761 | Continued From page 10<br><br>c. One multi-dose package of Ipratropium Bromide and Albuterol Sulfate 0.5 milligram (mg)/3mg per 3 milliliter (ml) inhalation vials. (Manufacturer ' s recommendation that once the foil pouch is opened, use vial within one week).<br><br>d. One multi-dose 10ml bottle of Latanoprost 0.005% solution eye drops. (Manufacturer's recommendation to discard 6 weeks after opening).<br><br>Unit Manager #1 verified the multi-dose medications were not dated and she removed them from the medication cart and discarded them. She indicated nurses and med aides were to write the date on all multi-dose medications upon opening and check dates prior to administration. She stated she did not realize they were not dated. She also stated that unit managers were to check med carts weekly, the pharmacy consultant checks medication carts for undated medications monthly and the administration staff audit carts monthly.<br><br>An interview was conducted with the pharmacy consultant on 01/22/24 at 8:30 AM. He stated he comes to the facility once a month to perform medication audits and education when needed. He indicated he audits one medication cart, one medication room, and one medication pass monthly. He also stated he<br><br>was here last week but did not audit 300 hall cart. When he audits the medication carts some things, he was looking for would include expired medications, lose pills, and if multiuse medications have an open date labeled on them. He further indicated that he had educated staff in | F 761 | and were not allowed to work until education has been completed. This will be added to the New Hire education.<br><br>The Director of Nursing and/or Nurse Administration will audit all 5 medication carts/storage rooms weekly times 4 weeks, then 3 medication carts/storage rooms weekly times 4 weeks then 1 medication cart/storage room weekly times 4 weeks. The DON will report the findings of these audits to the Quality Assurance Committee for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.<br><br>Date of Compliance 02/02/2024 | |

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| F 761 | Continued From page 11<br>the past on labeling multi-dose medications with an open date upon opening and this was an ongoing issue.<br><br>An interview was conducted with the Director of Nursing (DON) on 01/23/24 at 3:20 PM. He stated it was the nurse ' s and med aides ' responsibility to date multi-dose medications upon opening and they should be checking for dates daily prior to administration. He also stated all multi-dose medications were to be dated when opened. He then stated there should not have been unlabeled multi-dose medications on the medication cart. | F 761 | | |
| F 835 SS=D | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to provide effective leadership and implement effective systems to thoroughly investigate possible diversion (the transfer of a controlled medication from a lawful to an unlawful channel of distribution or use) of missing narcotic medications from 100 hall medication room.<br><br>The finding included:<br><br>An attempt to interview the Weekend Supervisor was made on 01/23/24 at 1:02 PM without | F 835 | The facility administration failed to provide effective leadership and implement effective systems to thoroughly investigate possible diversion of missing narcotic medications from the 100 hall medication room.<br><br>On 1/24/2024, the Regional Director of Clinical Services educated the Facility's Administrative Staff of the significance of conducting a thorough investigation when a suspicion of drug diversion has been reported. The Director of Nursing | 2/2/24 |

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| F 835 | Continued From page 12<br>success.<br><br>The Weekend Supervisor ' s statement revealed he reported possible narcotic diversion on 08/20/23 about 5:30 AM. He reported that the door to the medication room on 100 hall was propped open, upon entering the room, a pharmacy tote's secure tags (tags applied to both ends of the tote to secure it shut) were cut and sitting on top of the tote. Upon further review of the tote, it was noted that the narcotic sheet that was in the tote was missing along with a bubble pack containing 16 Oxycodone 5mg tabs.<br><br>A phone interview was conducted with the Staff Development Nurse on 01/23/24 at 1:24 PM. She stated she was made aware of missing narcotic medications at the facility on 08/20/23 between 5:30 and 6:00 AM by the weekend supervisor. She indicated she arrived at the facility on 08/20/23 between 8:00 and 9:00 AM to start her investigation for possible diversion of narcotic medications. She also stated she notified law enforcement, and they came to the facility to take the report. She then indicated she received a statement from one nurse and one nursing assistant stating they did not notice anyone going in the medication room except one nurse when she was retrieving the Covid box. She further stated she did not remember who she interviewed during her investigation.<br><br>Investigation records revealed approximately 8 nurses, 7 med aides, and 28 nursing assistants (NAs) worked in the building from 08/19/23 through the morning of 08/20/23. The investigation records revealed four written statements, two of the four statements referred to if they had observed anyone in the med room or | F 835 | conducted an audit on 1/24/2024 of the narcotic sheets and pharmacy returns to ensure no other diversion had taken place.<br><br>On 1/24/2024, the Regional Director of Clinical Services educated the Administrator and Director of Nursing on the Importance of developing an effective system to investigate any suspicion of drug diversion thoroughly. Administrator and DON educated regarding interviewing all staff working the hall when a diversion is discovered.<br><br>The DON will complete an audit of 5 residents with prescribed narcotics to ensure no suspicion of drug diversion 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. Any suspicion of drug diversion will be investigated immediately. Director of Nursing will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be made if further monitoring is necessary.<br><br>Date of Compliance: 2/2/2024 | |

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| F 835 | Continued From page 13<br>observed anyone with medications.<br><br>During an interview with the Director of Nursing (DON) on 01/23/24 at 3:20 PM he explained that he returned to work on 08/21/23 from a bereavement time off period. He indicated he completed the possible narcotic medication diversion investigation. He verified a police report had been completed and a report was sent to the Drug Enforcement Administration (DEA). He stated during the investigation he located the missing narcotic sheet along with the empty narcotic bubble pack medication card in a shred box in the 100 hall locked nourishment room. All 16 oxycodone tablets had been removed from the bubble pack. He also stated he had not interviewed all nursing staff that had worked on the weekend that the alleged diversion took place. The staff he interviewed were the nurses and med aides that worked the medication cart that would have handled the narcotic medication and/or the tote they were stored in. He verified that due to the medication room door being propped open all staff had access to the narcotic medications located in the tote. After completing the facility investigation, the facility was unable to determine who removed the narcotic medications from the medication room.<br><br>During a phone interview with Administrator #2 on 01/24/24 at 3:39 PM he stated he did not participate in the possible diversion investigation. He then stated all he knew was that they were unable to determine who removed the narcotic medications from the medication room. | F 835 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) | F 867 | | 2/2/24 |

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| F 867 | Continued From page 14<br>§483.75(c) Program feedback, data systems and monitoring.<br>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:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§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.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§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. | F 867 | | |

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| F 867 | Continued From page 15<br>§483.75(d) Program systematic analysis and systemic action.<br><br>§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.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(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<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§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.<br><br>§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. | F 867 | | |

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| F 867 | Continued From page 16<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§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:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and | F 867 | The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the recertification surveys between the years between 2021 and 2021. Facility's Quality | |

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| F 867 | Continued From page 17<br>complaint survey on 5/6/21. This was for one deficiency that was cited in the area of Respiratory/Tracheostomy care and Suctioning. In addition, two additional deficiencies were cited during the annual recertification and complaint survey on 12/1/22 in the areas of Respiratory/Tracheostomy care and Suctioning and Label/Store Drugs and Biologics. The duplicate citations during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program.<br><br>The findings included:<br><br>The citations are cross referenced to:<br><br>1) F695- Based on observations, record review, and staff and Medical Director interviews, the facility failed to obtain Physician orders for continuous oxygen (Resident #73). This was for 1 of 2 residents reviewed for respiratory care. During the facility's annual recertification and complaint survey on 5/6/21, the facility failed to administer oxygen at the prescribed rate for 2 of 2 residents reviewed for respiratory care.<br><br>During the facility's annual recertification and complaint survey on 12/1/22, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen for 2 of 5 residents reviewed for respiratory care. Additionally, the facility failed to secure oxygen tanks that were not in use for 1 of 4 observations.<br><br>2) F761- Based on observations, record review and staff interviews, the facility failed to label multi-dose medications with the date they were opened on 1 of 3 medication carts reviewed (the 300 Hall Medication Cart). | F 867 | Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint survey on 5/6/2021 for one deficiency in the area of Respiratory/Tracheostomy care and Suctioning. In addition, the QAPI failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint survey on 12/1/22 in the areas of Respiratory/Tracheostomy care and Suctioning and Label/Store Drugs and Biologics.<br><br>Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued.<br><br>The Administrator initiated an in-service to all administrative staff on 1/24/2024 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement | |

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| F 867 | Continued From page 18<br><br>During the facility's annual recertification and complaint survey on 12/1/22, the facility failed to: 1) discard expired medications 2) keep a medication refrigerated per manufacturer guidelines 3) label medications with the date they were opened and 4) to keep a treatment cart locked and secured.<br><br>In an interview with the Administrator on 1/24/24 at 10:00 AM, she indicated there had been recent turnover with staff and felt that education was needed for ensuring oxygen orders were in place, to check the medication carts for expired medications and to ensure that medications were dated when opened. | F 867 | activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education.<br><br>The QAPI Committee will review the compliance audits to evaluate continued compliance. This plan of correction was initiated on 1/24/2024 by the Administrator. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction.<br><br>Date of Compliance: 2/2/2024 | |