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MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/12/24 through 02/16/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5YES11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/12/24 through 02/16/24. Event ID# 5YES11. The following intakes were investigated: NC00205698, NC00206898, NC00209611, NC00209812, NC00210688, NC00210790, NC00211264. 1 of 15 complaint allegations resulted in deficiency.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation 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 interviews with residents, staff, and physician, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 4 of 4 residents (Resident #16, #17, #35, and #116) reviewed for misappropriation of residents' property. The findings included:	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/09/2024

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The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised on September 11, 2017, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property.

A review of the initial allegation report dated 07/08/23 revealed the facility became aware of the misappropriation of residents' property on 07/08/23 at 6:35 AM when a total of 4 tablets of oxycodone (a semi-synthetic narcotic analgesic for pain) had potentially been diverted (1 tablet each for Resident #16, #17, #35, and #116) by Nurse #1.

The 5-day investigation report dated 07/14/23 revealed on 07/08/23, 4 tablets of oxycodone 5 milligrams (mg) were signed out as given by Nurse #1. Interviews with all the 4 residents by the Assistant Director of Nursing (ADON) revealed that they did not ask for or receive any oxycodone that morning. Nurse #1 was asked to do a drug screening, but she refused to comply and became belligerent. The allegation of diversion of Residents' drugs was substantiated and Nurse #1 was terminated on 07/08/23.

An interview was conducted with the Director of Nursing (DON) on 02/15/24 at 2:27 PM. She stated the incident occurred on 07/08/23 morning. NA #1 noticed that she had difficulty finding Nurse #1 several times during the 7 PM through 7 AM shift on 07/07/23 night. NA#1 noted Nurse #1 had spent a lot of time in the restroom repeatedly that night. At one point, NA#1 went into the same bathroom immediately after Nurse #1 came out and saw some unknown white powders scattered on top of the sink in the bathroom. NA#1 took a picture and texted it to her around 4:30 AM that

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morning. She notified the on-call Administrator and corporate nurse consultant for further instructions. She called Nurse #2 who was the second nurse on duty that night around 5:30 AM and was told that Nurse #1 stayed in the bathroom repeatedly for long periods of time that night. She instructed Nurse #2 to begin the investigation immediately by reviewing the MARs and the controlled medication count sheets. Nurse #2 noted Nurse #1 had signed out oxycodone for 4 Residents within a short time frame of 30 minutes during that shift. DON stated these residents normally would not request pain medication during that time. She instructed the ADON at that time to go to the facility to start the on-site investigation immediately. Interviews with all 4 residents whose oxycodone was signed out by Nurse #1 by ADON revealed that they had not requested nor received any oxycodone from Nurse #1 that night. Nurse #1 was told later that she was suspected of drug diversion and instructed to submit urine specimen for a drug screening. However, Nurse #1 refused to comply. She was asked to surrender the medication cart key and being escorted out of the building by the ADON. Later, Nurse #2 claimed that Nurse #1 had attempted to get a urine specimen from her to be used for drug screening and was being rejected. She ordered ADON to assess all the affected residents immediately. Then, the ADON informed all the residents and families affected by the incident, notified the Medical Director (MD), reported to North Carolina Department of Health & Human Services (NC DHHS), the Board of Nursing (BON), and the local Sheriff's office. The ADON further investigated all other residents for potential drug diversion and determined that it affected 4 residents, and 4 tablets of oxycodone 5 mg were potentially diverted. All the missing

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drugs were replaced and paid for by the facility after the incident. She ordered ADON to start an in-service related to drug diversion, safeguarding of controlled medications and it was completed 07/14/23.

An attempt to conduct a phone interview with Nurse Aide (NA) #1 on 02/14/24 at 6:05 PM was unsuccessful. She did not return the call.

An attempt to conduct a phone interview with Nurse #1 on 02/14/24 at 6:43 PM was unsuccessful. She did not return the call.

An attempt to conduct a phone interview with the former Assistant Director of Nursing (ADON) on 02/14/24 at 6:06 PM was unsuccessful. He did not return the call.

An attempt to conduct a phone interview with Nurse #2 on 02/14/24 at 6:11 PM was unsuccessful. She did not return the call.

All the 4 Residents affected by the incident were in the facility when it occurred on 07/08/23.

Resident #35 and Resident #116 were not present in the facility at the time of the recertification and complaint investigation survey conducted from 2/12/24 through 2/16/24.

Resident #17 was admitted to the facility on 02/25/14 with diagnoses including polyneuropathy. The quarterly Minimum Data Set (MDS) dated 01/02/24 coded him with an intact cognition.

Resident #35 was admitted to the facility on 02/14/20 with diagnoses including age-related

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osteoporosis. The quarterly MDS dated 01/08/24 coded her with a severely impaired cognition. She expired in the facility on 02/01/24.

Resident #16 was admitted to the facility on 08/17/22 with diagnoses including chronic pain. The quarterly MDS dated 11/16/23 coded her with a moderately impaired cognition.

Resident #116 was admitted to the facility on 07/03/23 with diagnoses including osteoarthritis. The admission MDS dated 07/09/23 coded her with an intact cognition. She was discharged home on 07/12/23.

A review of the physician's order revealed 4 Residents affected by the incident had the following orders:
- Resident #16 - oxycodone 5 mg, take 1 tablet by mouth once every 6 hours as needed for pain. Initiated 08/17/22.
- Resident #17 - oxycodone 5 mg, take 1 tablet by mouth once every 8 hours as needed for pain. Initiated 11/22/22.
- Resident #35 - oxycodone 5 mg, take 1 tablet by mouth once every 6 hours as needed for pain. Initiated 11/22/22.
- Resident #116 - oxycodone 5 mg, take 1 tablet by mouth once every 6 hours as needed for pain. Initiated 07/03/23.

A review of the controlled medication count sheets revealed 1 tablet of oxycodone 5 mg was signed out by Nurse #1 on 07/08/24 for Resident #116 at 4:30 AM, Resident #17 at 4:45 AM, Resident #16 at 4:50 AM, and Resident #35 at 5:00 AM.

A review of medication administration records

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(MAR) revealed 1 tablet of oxycodone 5 mg was signed out by Nurse #1 on 07/08/24 for Resident #116 at 4:39 AM, Resident #17 at 4:43 AM, Resident #16 at 4:50 AM, and Resident #35 at 4:49 AM.

An interview was conducted with Resident #17 on 02/13/24 at 9:35 AM. He recalled the incident related to drug diversion a few months ago. When a management staff interviewed him during the incident, he told him that he did not request the pain medication on 07/08/23 around 4:00 AM to 5:00 AM and it was not given by the nurse that morning.

During an interview conducted on 02/14/24 at 3:22 PM, Resident #16 could not recall the incident related to diversion of her pain medication by Nurse #1 that occurred a few months ago.

During a phone interview conducted on 02/15/24 at 4:21 PM, the MD stated he was notified of potential controlled medication diversion on 07/08/23 morning and provided with the list of residents affected. He stated all the affected residents were assessed immediately without any adverse consequences noted as the missing drugs were used "as needed" basis. He added all the missing medications were replaced and paid for by the facility later.

The facility provided the following corrective action plan with a completion date of 07/31/23:

Problem Statement:
On 7/8/23 at approximately 4:23 am, Nurse Aide #1, notified the Director of Nursing to report a suspicion of drug diversion. She reported that

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immediately after Nurse #1 came out of the restroom, she noted a white powdery substance on multiple areas of the bathroom sink. A phone interview was conducted with Nurse #2 who was present in the facility at approximately 5:30 am. Nurse #2 confirmed her suspicions of drug diversion as well. Nurse #2 stated that she observed Nurse #1 pull medications from the controlled drawer of her cart however did not see Nurse #1 give these medications. Nurse #2 looked at the Medication Administration Record and the Controlled substance log for the cart of Nurse #1 and observed Oxycodone 5mg signed out as given for the following residents: Resident #116, #16, #17, and #35. All oxycodone 5mg medication were ordered as needed and were signed out both in Point Click Care and in the Controlled Substance Count log as given. The timeframe ranged between 4:30 am and 5:00 am on 7/8/23. The Assistant Director of Nursing entered the facility at approximately 6:00am on 7/8/23 and continued investigation. He interviewed Nurse #2 and Nurse Aide #1. He also interviewed resident # 116, #16, #17, and #35. During these interviews, the 4 residents identified in the investigation stated they had not asked nor received any pain medications after the identified time of approximately 4:00am. The nurse assessed these four residents for pain at this time and none of the 4 were noted to have pain at the time of their interview and had not requested pain medication at the time of the incident. At 6:35am, the Assistant Director of Nursing attempted to conduct an interview with Nurse #1 to discuss the incident and obtain a statement and a drug screen, however Nurse #1 refused. Nurse #1 was suspended at this time pending investigation and escorted from the facility with Nurse #2 as a witness. The Medical Director was informed of

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this concern at approximately 8:16 am with no further orders given. Resident representatives were also informed at this time as well. A report was made to the Department of Health and Human Services at approximately 8:40 am followed by a call to the Macon County Sheriff's Office at approximately 8:58am. Nurse #1 was terminated on 7/8/23. The Director of Nursing filed a report alleging controlled substance diversion with the North Carolina Board of Nursing on 7/10/23 with additional documentation requested and sent on 7/12/23.

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

Interviews were conducted by the Assistant Director of Nursing on 7/8/23 with the 4 residents having been identified as having controlled medications signed out during the hours identified in the investigation to determine if the medications had been given. It was determined that these 4 residents were identified as having not received medications that were signed out by Nurse #1. Pain scales were performed for all residents identified by a licensed nurse on duty on 7/8/23 verbally at approximately 6:00am prior to the interview with Nurse #1. No complaints of pain were identified. Pain scales were also conducted again throughout day shift on this same day for these same residents. The Medical Director was made aware with no new orders given. The pharmacy was notified, and 1 oxycodone 5mg tablet was replaced for each resident identified in the investigation.

Address how the facility will identify other residents having the potential to be affected by

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the same deficient practice:

A medication count of all controlled drugs was conducted by the Assistant Director of Nursing and the Director of Nursing on 7/8/23 to ensure all controlled medications were accurate and available as ordered by the physician. Any medications that were diverted were replaced by the pharmacy as appropriate. No concerns were identified during this audit. All residents who received controlled pain medications were assessed for pain to include signs and symptoms of pain both verbal and non-verbal to ensure pain levels were being addressed appropriately. Any concerns were reported to the charge nurse, Director of Nursing or Assistant Director of Nursing and addressed immediately. The Medical Director was notified, and orders were given as appropriate.

An in-service was initiated on 7/10/23 by the Staff Development Coordinator on Abuse Neglect, Misappropriation, Reporting, Reporting, Code of Ethics, and Diversion. An in-service was also initiated on 7/13/23 by the Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator with all nurses and medication aides to include agency staff regarding Controlled Substance Diversion to include: the definition, implications, and the process for returning controlled medications. All education was completed by 7/14/23. Any nurse or medication aide, to include agency staff that have not completed the education as stated above by the completion date will do so by their next scheduled shift. Any newly hired licensed nurse, medication aide or agency staff will receive the above stated in-service education during orientation prior to their first shift.

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The pharmacy will conduct monthly cart and med-pass audits to ensure nurses and medication aides, including agency nurses, are following policy and procedures related to medication administration. All residents will be monitored daily and every shift for signs and symptoms of pain both verbal and non-verbal to ensure pain levels are being addressed appropriately. Any concerns are reported to the charge nurse, Director of Nursing or Assistant Director of Nursing and addressed immediately.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

100% of all residents receiving controlled medications will be reviewed by the Assistant Director of Nursing/Director of Nursing once weekly x4 weeks and compared to the Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the controlled medications are being administered or have been returned to pharmacy as required per policy as well as no signs of drug diversion utilizing a Controlled Substance Audit tool. All concerns will be addressed during the audit including re-education of all licensed nurses and medication aides to include agency nurses. Any newly hired/agency employees who are licensed nurses or medication aides will receive education during orientation prior to their first shift. Nursing Administrative staff to include Director of Nursing, Assistant Director of Nursing,

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Staff Development Coordinator, or Quality Improvement Nurse, will conduct pain assessments and interviews of 5 residents daily who have pain for 4 weeks. Any concerns will be addressed and investigated immediately. The Medical Director and Responsible Party will be notified of any concerns and care-plans/care-guides will be updated as appropriate.
The Administrator or Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement Committee monthly for 1 month. The Quality Assurance Performance Improvement Committee will meet monthly for 1 month and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. QAPI meetings were held on 8/31/23 and 9/29/23.

Date of Compliance: 7/31/23

The facility's corrective action plan with a correction date of 07/31/23 was validated onsite on 02/16/24 by record review, observations, and interviews with nursing staff and the DON.

Medication Administration observations were conducted on 02/14/24 and it consisted of 25 medications, 3 different residents, and 3 Nurses. Controlled medication was pulled from the double-locked compartment in the medication cart during the medication pass observation. The nurse documented the retrieval of controlled medication in the controlled medication count sheet properly. Random samples of 3 controlled medications were pulled from each medication cart to verify accuracy and the controlled substance counts were consistent with the

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records in the count sheets.

An observation was conducted during a shift transition. The arriving and the departing nurses started the process by counting the total number of blister cards containing controlled medication in the double-locked compartment in the medication cart to verify the recorded balance in the count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the count sheet was consistent with the actual counts. The departing nurse read out the number of pills for each blister card from the controlled medication count sheets and the arriving nurse pulled the blister card to verify the quantity. After all the counts were completed without any discrepancies, the arriving nurse signed the controlled medication count sheet before the departing nurse passed the medication cart key to her.

Nursing staff confirmed during the interview that they had received in-service training on "Abuse, neglect, misappropriation, reporting, code of ethics, and diversion" and "Definition, implications, and the process for returning narcotic medications". They were assigned to review the handouts related to the in-service prior to the training. The training was conducted in-person by DON, ADON, and the Staff Development Coordinator (SDC), and it included multiple examples and scenarios. A total of 79 staff completed the training and signed in the in-service records. The training was completed on 07/14/23.

Review of audit records revealed all residents receiving controlled medications were audited by the DON or ADON once per week for 4 weeks by

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F 602	Continued From page 12 comparing controlled substance count sheets, MAR, and the controlled medication return sheets. On the other hand, DON and ADON had conducted pain assessments and interviews with 5 residents who had pain once daily for 4 weeks to ensure all the pains were addressed and the facility was free of drug diversion. The Administrator or Director of Nursing presented the findings of the audit tools to the Quality Assurance Performance Improvement Committee (QAPI) on 08/31/23. Interview with DON revealed she started the in-service immediately after the incident to re-educate all the licensed nurses and medication aides. She audited the medication cart at least once per week randomly for 4 weeks to ensure all controlled medication counts were conducted properly and the count sheets were documented properly. She stated the interventions were successful as the facility did not have any similar drug diversion issues since then. The compliance date of 7/31/23 was validated.	F 602		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 645		3/15/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 645	Continued From page 13 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and	F 645		

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F 645	Continued From page 14 (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to submit a request for an evaluation for an updated Preadmission Screening and Resident Review (PASRR) determination for a resident who was admitted to the facility with mental health disorders and received a change in treatment (Resident #37) for 1 of 2 residents reviewed for PASRR. The findings included: Record review of the North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document dated 05/08/21 revealed Resident #37 had a Level I PASRR effective 05/08/21. There were no requests for a Level II PASRR evaluation submitted or completed since 05/08/21. Resident #37 was admitted to the facility on 10/24/23 with diagnosis that included vascular dementia severe with mood disturbance, bipolar disorder, delusional disorders, psychological and	F 645	Macon Valley F645 Pre-Admission Screening and Resident Review (PASARR) Screening for MD & ID " Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. " Macon Valley Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and	

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F 645	Continued From page 15 behavioral factors associated with disorders or diseases classified elsewhere. Review of the admission Minimum Data Set (MDS) dated 10/30/23 revealed Resident #37 had not been evaluated by Level II PASRR and determined to have a serious mental illness, intellectual disability or other related condition. Resident #37 received antipsychotic medication on a routine and as needed basis. Record review of the physicians' orders for Resident #37 revealed in part an order dated 12/30/23 for RisperDAL Consta Intramuscular Suspension Reconstituted Extended Release (antipsychotic medication) 37.5 milligrams (MG) Injection intramuscularly one time a day every 14 day(s) for behavioral and psychological symptoms of dementia (BSPD). Record review of the medication administration records (MAR) from December 2023 to February 2024 revealed it was documented that Resident #37 was administered RisperDAL Consta Intramuscular Suspension Reconstituted Extended Release 37.5 milligrams (MG) Injection intramuscularly per the physician's order. An interview on 02/16/24 at 9:27 AM with the Admission/ Marketing Director/ Interim Social Services revealed that she received PASRR training from the Admissions Director at the time and corporate support person who is no longer with the company. She stated the former social worker would do monthly audits. MDS will notify her of significant changes which triggers her to request a level II PASRR as well as communication from nursing staff about significant changes. She stated that she attends	F 645	Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Problem Statement: " It was alleged that on 10/24/23 a resident was admitted to the facility with diagnosis and treatments that required screening for a Level II Pre-Admission Screening and Resident Review (PASRR). The facility failed to submit for a Level II PASRR screening during the admission process. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " A request for a Level II PASRR screening was submitted to NC MUST by the Admissions Coordinator and a Level II PASRR was issued on 2/23/24 for Resident #37. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 3/6/24, the Minimum Data Set Nurse (MDS) and the Assistant Director of Nursing conducted a 100% audit of all resident□s diagnosis and orders to determine any residents that met the criteria for a Level II PASRR screening. The Social Worker and MDS nurse compared the data identified in the audit	

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F 645	Continued From page 16 the morning meeting but does not always stay for the clinical interdisciplinary team (IDT). She stated that if she did stay for the clinical IDT portion of the daily morning meeting it would help with her needing to know if residents should be considered for a level II evaluation. She feels that Resident #37 not receiving a level II evaluation after her change in treatment was just overlooked and that she would get it fixed. An interview on 02/16/24 at 1:38 PM with the Administrator revealed he expected the person responsible for monitoring Level II PASRRs to submit requests for evaluation when appropriate.	F 645	to determine if any resident required a submission or resubmission for a Level II PASRR screening. Any areas of concern were reported to the Administrator and corrected immediately. The audit was completed by 3/8/24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " On 3/8/24 the Administrator conducted an in-service on Level II PASRR screening with the Admissions Coordinator, the Social Worker, the MDS nurse, the Director of Nursing, and the administrative nursing team to include the Assistant Director of Nursing, the Staff Development Coordinator, and the Unit Manager with emphasis on referral for evaluation/re-evaluation of PASRR upon admission to include transfer from another facility, any changes in mental health status or new Level II PASRR qualifying diagnosis. Any newly hired staff, to include agency, Admissions Coordinator, Social Worker, MDS nurse, Director of Nursing or administrative nursing staff, to include the Assistant Director of Nursing, the Staff Development Coordinator, and the Unit Manager after the completion of this in-service will complete the in-servicing during orientation prior the start of their first shift. " Upon admission to the facility, the Admissions Coordinator and the Director of Nursing will review all residents who are ordered psychotropic medications	

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F 645	Continued From page 17	F 645	and/or have a mental health diagnosis to determine the need for a Level II PASARR screening. If either are identified, a level II PASARR screening will be requested at that time. " The Director of Nursing/The Assistant Director of Nursing/Unit Manager will review orders and progress notes daily in Cardinal IDT to identify any new psychotropic medications or diagnosis for mental illness. If any are identified, for residents that do not have a current Level II PASARR, a request for one will be made. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing/Minimum Data Set Nurse (MDS) will audit 3 residents charts weekly x4 weeks to review any progress notes, new diagnosis, and orders that would indicate the need for a Level II PASRR screening. Any concerns identified will be addressed immediately. " The Social Worker or Administrator will present all audits to Quality Assurance Performance Improvement (QAPI) team monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 3/15/24	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		3/15/24

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F 700	Continued From page 18 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the Responsible Party and staff the facility failed to assess the risk of entrapment after the placement of an alternating pressure air mattress for a cognitively impaired resident dependent on staff for bed mobility (Resident #27) and failed to complete the bed rail assessment and obtain informed consent from the Responsible Party (Resident #28) for 2 of 3 residents reviewed for bed rails. Findings included: 1. Resident #27 was admitted to the facility on	F 700	Macon Valley -F700 Bedrails Problem Statement: " It was alleged that the facility failed to assess resident #27 and resident #28 at the quarterly assessment to determine the continued need for bedrails to mitigate the risk of entrapment and to promote resident mobility. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 700	Continued From page 19 08/15/18 with diagnoses including dementia and chronic obstructive pulmonary disease. A physician's order with a start date of 03/28/22 with directions to validate the settings of the alternating pressure air mattress. Review of the alternating pressure air mattress operation manual for the type used on the bed of Resident #27 revealed no warnings or contraindications for use with bed rails. The care plan focus area for bed rails revised on 09/05/23 indicated Resident #27 required the use of bilateral bed rails to increase or maintain her current level of bed mobility for turning and repositioning. Interventions included reviewing the risks and benefits for the use of bed rails with the resident and/or resident's representative. The care plan focus area for skin breakdown revised on 09/07/23 was for the placement of a winged tipped air mattress on the bed of Resident #27 with interventions including to validate the pressure setting on the winged tipped air mattress. Review of the bed rail assessment dated 09/16/23 indicated alternatives tried prior to placing included rehab, positional devices, review of medications, and pain management. The benefits listed for the use were to promote dignity and prevent transfer without assistance. The assessment indicated there were no risks for the use of bed rails and an attempt to notify the Responsible Party (RP) of Resident #27 was made by leaving a voicemail to return the call. The quarterly Minimum Data Set assessment	F 700	practice: " On 2/16/24, a device assessment was performed for resident #27 to determine the continued need for bedrails. It was determined that the resident was no longer using bedrails for mobility. The bedrails were removed on 2/16/24 by the Maintenance Director. Resident□s care plan and care guide were updated at that time. " On 2/16/24, a device assessment was performed for resident #28 to determine the continued need for bedrails. It was determined per the assessment that the resident continues to use bedrails for mobility to include ability to reposition and turn self. The Maintenance Director and Administrator measured resident's bed at this time to ensure there was no risk for entrapment related to the continued use of bedrails as outlined in the State Operations Manual. No risk was identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 3/8/24 100% audit of all residents using bedrails in the facility began to ensure a current device assessment was completed and that the bedrails continued to be appropriate for mobility. Any residents who no longer met the criteria as defined in the State Operations Manual was removed immediately and the Care Plan/Care Guide was updated. The	

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F 700	Continued From page 20 dated 01/09/24 indicated Resident #27's cognition was severely impaired and extensive assistance was needed for bed mobility. No falls had occurred since the previous MDS assessment and bed rails were not used as a restraint. Review of the bed rail assessment dated 01/17/24 revealed the questions including what alternatives were tried, what were the risk and benefits, and was the risk, benefits, and alternatives explained to the Responible Party (RP) of Resident #27 and the RP was notified were left blank. None of the questions were completed on the assessment for the use of bed rails. During an observation on 02/12/24 at 12:22 PM Resident #27 was in bed with bilateral quarter bed rails in the up position. A winged tipped alternating pressure air mattress was in place with the setting lights on to indicate it was functioning. There was a gap between the air mattress and bed rail of approximately 3 to 4 inches wide on one side of bed. An observation and interview were conducted on 02/15/24 at 9:46 AM with Resident #27. Resident #27 was in bed with bilateral bed rails in the up position with the alternating pressure air mattress functioning. Attempts to ask Resident #27 about her ability to use the bed rail were unsuccessful. Resident #27 stated she could hear the questions but did not understand what was being asked. During an interview on 02/15/24 at 9:56 AM Nurse Aide (NA) #2 stated Resident #27 required extensive 1-person assist with bed mobility and was able to grab hold of the bed rail and hold on during care. NA #2 was unsure if Resident #27	F 700	Maintenance Director and the Maintenance Assistant then measured all resident beds who continued to have bedrails to ensure no risk for entrapment was noted according to the guidance defined in the State Operations Manual. Any concerns were addressed immediately. The audit will be completed by 3/13/24. " Any newly admitted or re-admitted residents will have a device assessment for bedrails during the initial admission or re-admission assessment. If bedrails are determined appropriate per the guidelines in the State Operations Manual, the Maintenance Director and the Administrator will measure to ensure there is no risk for entrapment. Measurements will be determined by the guidelines outlined in the State Operations Manual. Any resident deemed appropriate for bedrails will be discussed in Cardinal IDT 5x/week with the Interdisciplinary Team (IDT) team. " Any resident who has a change of condition requiring the placement of a different mattress will require a physical device assessment conducted by a licensed nurse. The results will be taken to the Interdisciplinary Team (IDT) during the morning Cardinal meeting by the Director of Nursing or the Assistant Director of Nursing to determine if need is indeed present and changes to the Care Plan and Care Guide will be made as appropriate. Address what measures will be put into place or systemic changes made to	

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F 700	Continued From page 21 was able to use the bed rail to reposition when in bed without assistance from staff. An interview was conducted on 02/15/24 at 10:09 AM with the Maintenance Assistant. The Maintenance Assistant revealed the facility used a computer system that generated tasks to inspect bed rails, but he was not sure how frequently the safety inspections were done. He revealed Housekeeping was responsible for placing the air mattress on the bed and maintenance was responsible for bed rail safety inspections. He revealed bed rail safety inspections were done to ensure they properly attach to the bed frame and lock in place when moving up and down. He stated he did not officially check for gaps between the mattress and bed rails and was not made aware a safety check needed to be done when a mattress was replaced including an alternating pressure air mattress. During an interview on 02/15/24 at 11:42 AM the Maintenance Director stated nursing made the initial request to install bed rails and maintenance was responsible for installation and monthly safety checks. He revealed the facility used a computer maintenance system that generated a list of tasks to complete for bed rail safety checks that included proper function but did not specify to check for gaps between the mattress and bed rail or complete if the mattress was replaced including an alternating pressure air mattress. The Maintenance Director revealed the computer-generated bed rail safety check printed in way that made it difficult to read when the last bed rail safety check was done for Resident #27. An interview was conducted on 02/16/24 at 11:17 AM with Director of Nursing (DON). The DON	F 700	ensure that the deficient practice will not recur: " The Administrator will ensure that the Plan of Correction has been implemented by performing the following actions: " On 3/12/24, the Nurse Consultant conducted education with the facility Administrator to ensure all beds with bedrails were being measured to ensure there was no risk for entrapment as outlined in the State Operations Manual. " On 3/12/24, the Administrator conducted 100% education with the facility Maintenance Director and the Maintenance Assistant to ensure all beds with bedrails were being measured to ensure there was no risk for entrapment as outlined in the State Operations Manual. " The Director of Nursing began 100% education with all licensed nurses on 3/12/24 and will be concluded on 3/13/24 with a focus on ensuring all residents who require a device placement will receive a device assessment prior to any device being placed. Any concerns will be addressed with the Administrator and the Director of Nursing Immediately. Any newly hired staff member to include agency staff member hired after 3/13/24 will receive education during orientation prior to the start of their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The facility Maintenance Director and	

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F 700	Continued From page 22 stated bed rail assessments were done upon admission, quarterly, and when the resident had a change of condition. The DON stated Resident #27 used the bed rails to grab hold of when nursing staff were doing care, but she was unsure if caught against the bed rail Resident #27 was physically able to move away from it. The DON revealed the assessment dated 01/17/24 was not completed and Resident #27 was not assessed for the risk of entrapment. The DON stated she would expect the assessment on 01/17/24 to be completed and include information about alternatives tried, the risk and benefits, and that the risk, benefits, and alternatives were explained to the RP and consent was obtained. The DON revealed a bed rail assessment was not done when the alternating pressure air mattress was put on the bed of Resident #27, and she was not aware an assessment was needed to assess the risk of entrapment when the air mattress was placed. During an interview on 02/16/24 at 1:42 PM the Administrator stated bed rail assessments were done upon admission, quarterly, and if there was a change in the resident's condition. He stated it was the responsibility of the nurses to complete the bed rail assessments and was his expectation they were done. The Administrator revealed he was not aware an assessment should be completed for the risk of entrapment after the placement of an alternating pressure air mattress for a cognitively impaired resident. He revealed a tool could be utilized to check for gaps between the mattress and bed rail and he was checking on obtaining one to include on the safety inspections and the possibility of paper documentation for easier access of the inspections.	F 700	Administrator will audit 5 resident rooms per week x4 weeks to ensure the bedrails measure and meet the guidelines as outlined in the State Operations Manuel to prevent entrapment and are in good working order. " The Administrator or Maintenance Director will present audits to the Quality Assurance Performance Improvement Committee monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 3/15/24	

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F 700	Continued From page 23	F 700		

2. Resident #28 was admitted to the facility on 11/05/21 with diagnoses including Alzheimer's disease.

The bed rail assessment completed on 10/05/22 indicated quarter rails were in place to enhance independence with bed mobility and assist with turning and repositioning and that the risk, benefits, and alternatives were explained to the RP.

The most current bed rail assessment was completed on 03/17/23. The assessment indicated quarter rails were in place to enhance independence with bed mobility and assist with turning and repositioning. The assessment included information that the risk, benefits, and alternatives were explained to the RP. No other bed rail assessments were completed after 03/17/23.

The care plan focus area for bed rails revised on 06/28/23 indicated Resident #28 required the use to increase or maintain the current level of bed mobility or ability to safely transfer. Interventions included evaluate the continued use for effectiveness and appropriateness, the use of bedrails to assist resident to turn and reposition when in bed and to increase the ability to enter and exit the bed independently or at the highest mobility level.

The quarterly Minimum Data Set dated 11/16/23 revealed Resident #28 cognition was severely impaired and extensive assistance was needed for bed mobility. No falls had occurred since the previous MDS assessment and bed rails were not used as a restraint.

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Observations on 02/13/24 at 9:45 AM and 02/15/24 at 9:43 AM revealed Resident #28 was not in her room. Bilateral bed rails were secured in place on the bed and locked in the up position.

An interview was conducted with the RP of Resident #28 on 02/13/24 at 11:25 AM. The RP stated she did not recall being told about the risk or benefits for the use of bed rails. The RP stated Resident #28 was able to use the rails for bed mobility to reposition without the assistance of nursing staff.

An interview was conducted on 02/16/24 at 10:53 AM with Nurse #4 who was assigned to provide care for Resident #28. Nurse #4 revealed Resident #28 used the bed rails for mobility and repositioning. She revealed Resident #28 was able to sit at the edge of the bed and stand up using the bed rail to assist and could safely use the rails. Nurse #4 stated the nurses were responsible for completing bed rail assessments and were done on admission, quarterly, and as needed if the resident had a significant change in condition or decline in their mobility.

An interview was conducted on 02/16/24 at 11:17 AM with the DON. The DON stated bed rail assessments were done upon admission, quarterly, and when the resident had a change of condition. She confirmed the most recent two bed rail assessments for Resident #28 were completed on 10/05/22 and 03/17/23. The DON did not know why the bed rail assessments were not completed after 03/17/23.

During an interview on 02/16/24 at 1:42 PM the Administrator stated bed rail assessments were done upon admission, quarterly, and if there was

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F 700	Continued From page 25 a change in the resident's condition. He stated it was the responsibility of the nurses to complete the bed rail assessments and was his expectation they were done.	F 700		
F 756 SS=E	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. (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	F 756		3/15/24

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F 756	Continued From page 26 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 interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations and cholesterol levels for 1 of 5 residents reviewed for unnecessary medications (Resident #25). Review of the lipid guidelines published in 2019 by the American College of Cardiology and American Heart Association indicated a lipid panel should be conducted at baseline for patient receiving statin (medications used to lower cholesterol) therapy, then 4 to 12 weeks after statin therapy was started or when dosage was adjusted. Afterwards, lipid panel test should be repeated once every 3 to 12 months as needed. Resident #25 was admitted to the facility on 12/28/22 with diagnoses including hyperlipidemia (high level of lipids/fats in the blood). Review of Resident #25's medical records revealed the most recent lipid panel was done on 12/22/22 when Resident #25 was in the hospital prior to being admitted to the facility. The hospital list of active medications included ezetimibe give 10 milligrams (mg) daily and atorvastatin give 40 mg at bedtime. There were no other lipid panels included in the medical records after 12/22/22.	F 756	Macon Valley -F756 Drug Regimen Review, Report Irregular Problem Statement: " Based on the findings, it was alleged that the Consultant Pharmacist for the facility failed to provide a recommendation for monitoring of a lipid panel necessary for monitoring of the medications used to lower cholesterol per the recommended guidelines. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The Medical Director was notified on 2/14/24. A lipid panel was ordered and obtained by the nurse on duty for resident #25. The lipid panel resulted on 2/15/24 and was called to the Medical Director by the licensed nurse with no new orders received. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " The list of residents reviewed by the	

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F 756	Continued From page 27 A review of the active physician orders included to administer atorvastatin 40 mg at bedtime for cholesterol started on 12/28/22 and ezetimibe 10 mg at bedtime for cholesterol started on 12/29/22. A review of the Medication Administration Records (MAR) from January 2023 through February 2024 revealed Resident #25 received atorvastatin 40 mg and ezetimibe 10 mg at bedtime as ordered. Review of the Monthly Medication Regimen (MRR) for Resident #20 revealed the Consultant Pharmacist reviews were completed on the following days: 1/12/23, 2/8/23, 3/9/23, 4/6/23, 5/5/23, 6/5/23, 7/10/23, 8/17/23, 9/20/23, 10/21/23, 1/26/24. There were no recommendations made by the Consultant Pharmacist related to monitoring the lipid panel for the use of the medication atorvastatin and ezetimibe. During an interview on 02/15/24 at 10:54 AM Nurse #6 checked the active physician orders for ezetimibe 10 mg and atorvastatin 40 mg and stated both were current orders administered nightly by the nurses. An interview was conducted with the Medical Records Coordinator on 02/15/24 at 1:33 PM. She confirmed she was responsible for scanning lab test results in the electronic medical record and was unable to find a lipid panel for Resident #25 after being admitted to the facility on 12/28/22. An attempt to conduct a phone interview with the current Consultant Pharmacist on 02/15/24 at	F 756	pharmacy consultant for the last 30 days were reviewed by the Director of Nursing and the Assistant Director of Nursing on 3/8/24. Any residents who required medications for the monitoring of cholesterol were reviewed to ensure a lipid panel had been requested by the pharmacy consultant to the provider and an order was obtained. " On 3/6/24 the Director of Nursing and Assistant Director of Nursing conducted a 100% audit of all residents who are taking medications used to lower cholesterol. The audit was concluded on 3/8/24. Any resident not having a lipid panel drawn for the monitoring of cholesterol within the recommended guidelines was requested by the Medical Director and orders were obtained as appropriate. " Residents who are newly admitted or re-admitted will be reviewed in Cardinal IDT 5x/wk. by the Director of Nursing/Assistant Director of Nursing to ensure any medications that are used to lower cholesterol and require a lipid panel for the monitoring of cholesterol are requested upon admission from the Medical Director, ordered and obtained as determined in the recommended guidelines and as deemed appropriate by the Medical Director. " The monthly pharmacy recommendations will be reviewed each month by the Director of Nursing and the Assistant Director of Nursing. Any resident identified as receiving medications used to lower cholesterol will be reviewed to determine the last lipid panel obtained and request the lipid panel	

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F 756	Continued From page 28 3:54 PM was unsuccessful. He did not return the phone call. During a phone interview on 02/15/24 at 4:12 PM the MD stated a lipid panel was obtained every six months or annually for use of atorvastatin and ezetimibe. He revealed Resident #25 was taking both atorvastatin and ezetimibe to reduce cholesterol levels and would need a lipid panel for efficacy and to check liver function due to statin use can affect the liver. He revealed it was his expectation the Consultant Pharmacist alert him when labs needed to be done for the use of atorvastatin and ezetimibe. During a phone interview on 02/15/24 at 4:35 PM the Supervisor for the Consultant Pharmacist stated a lipid panel was a standard lab obtained when using statin medications. After he reviewed Resident #25's medical records, he stated the most recent lipid panel was obtained on 12/2022 by the hospital. After review of the Pharmacist Consultant MMR, he stated no recommendations were made to obtain a lipid panel. An interview was conducted on 02/16/24 01:30 PM with the Director of Nursing (DON). The DON stated the process was for the Consultant Pharmacist to make recommendations and the MD to follow up. She revealed labs were ordered by the MD as needed and there was no schedule in place for routine labs including a lipid panel but was something she would check on implementing. She was unsure why the lipid panel for Resident #25 was not ordered and stated it had been addressed. During an interview conducted on 02/16/24 at 1:38 PM the Administrator revealed he expected	F 756	for the monitoring of cholesterol from the provider as appropriate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The Director of Nursing will ensure the Plan of Correction has been implemented by performing the following actions: " The Nursing Consultant conducted education with the pharmacy consultant on 3/11/24 to review the guidelines for making recommendations to the physician for any resident receiving medications used to lower cholesterol. " The Director of Nursing conducted 100% education beginning on 3/8/24 and was completed by 3/11/24 with the nursing administrative staff (the Assistant Director of Nursing, the Staff Development Coordinator, and the Unit Manager) on the guidelines for labs being obtained for residents receiving medications used to lower cholesterol. This education provided an emphasis on ensuring these recommendations were included in the monthly pharmacy recommendations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing will audit 5 pharmacy recommendations per month for 2 months to ensure all residents that	

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F 756	Continued From page 29 the Consultant Pharmacist provide the appropriate recommendations for labs for the use of medications that require monitoring.	F 756	require a lab for monitoring of cholesterol has received the recommendation, that recommendation has been signed by the physician, and carried out by a licensed nurse. " The Director of Nursing or the Assistant Director of Nursing will present audits to the Quality Assurance Performance Improvement Committee monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 3/15/24	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		3/15/24

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F 757	Continued From page 30 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to monitor thyroid stimulating hormone (TSH) (Resident #20) and cholesterol levels (Resident #25) for 2 of 5 residents reviewed for unnecessary medications. The findings included: 1.A review of the guidelines published in 2017 by American Thyroid Association indicated TSH level should be checked about 6-8 weeks after starting levothyroxine or having a change in the dosage. Then, it should be monitored at least once a year to ensure TSH level remained wiin the normal ranges of 0.4 to 4.0 milli-international units per milliliter (mUI/mL). Resident #20 was admitted to the facility on 09/28/22 with diagnoses including hypothyroidism (A condition occurred when the thyroid gland could not make enough thyroid hormone to keep the body functioning normally). A review of Resident #20's lab records revealed her most recent TSH lab was completed on 02/03/23 when she was in the hospital. No subsequent TSH labs had been documented in her medical records since then. A review of the physician's order dated 02/05/23 indicated Resident #20 had an order to receive 1 tablet of levothyroxine 50 micrograms (mcg) by mouth once daily in the morning for thyroid	F 757	Macon Valley -F757 Drug Regimen Free of Unnecessary Drugs Problem Statement: " It was alleged that the facility failed to monitor thyroid stimulating hormone (TSH) and lipid panel levels during the timeframe required in the recommended guidelines for these medications for resident #20 and resident #25 residing in the facility. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The Medical Director was notified of the deficient practice on 2/15/24. A thyroid stimulating hormone (TSH) lab was ordered and obtained by the nurse on duty for resident #20. The TSH resulted on 2/16/24 and was called to the Medical Director by the licensed nurse with no new orders received. " The Medical Director was notified of the deficient practice on 2/14/24. A lipid panel was ordered and obtained by the nurse on duty for resident #25. The lipid panel resulted on 2/15/24 and was called to the Medical Director by the licensed nurse with no new orders received. Address how the facility will identify other	

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F 757	Continued From page 31	F 757		

disease. This order was discontinued on 02/09/24. However, it was restarted with the same dosage and directions on 02/13/24.

The quarterly Minimum Data Set (MDS) dated 12/13/23 coded Resident #20 with severe impairment in cognition.

A review of the medication administration records (MAR) from February 2023 through February 2024 revealed Resident #20 had received 1 tablet of levothyroxine 50 mcg once daily as ordered since it was started on 02/05/23 until it was discontinued on 02/09/24. Resident #20 resumed receiving the same dosage of levothyroxine again when it was re-started on 02/13/24.

An attempt to interview Resident #20 on 02/14/24 at 8:48 AM was unsuccessful. She was unable to engage in the interview.

During an interview conducted on 02/14/24 at 4:08 PM, Nurse #3 stated she had administered levothyroxine to Resident #20 as ordered at times. She did not recall receiving any lab order to check Resident #20's TSH level in the past few months.

An interview was conducted with the Medical Record Coordinator on 02/15/24 at 10:14 AM. She confirmed the most recent TSH lab for Resident #20 was conducted on 02/03/23. She could not find any TSH labs documented in the medical records for Resident #20 after 02/03/23.

A phone interview was conducted with the MD on 02/15/24 at 4:21 PM. He stated residents receiving levothyroxine on regular basis without checking TSH levels could have an increased risk

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

" A 100% audit of all residents who are taking medications that require monitoring for thyroid stimulating hormone (TSH) and lipid panel began on 3/6/24 and was completed on 3/8/24 by the Director of Nursing and the Assistant Director of Nursing. Any resident not having a lab obtained for monitoring of TSH or lipid panel levels within the recommended guidelines was requested by the Medical Director and orders were obtained as appropriate.
" Residents who are newly admitted or re-admitted will be reviewed in Cardinal IDT 5x/wk. by the Director of Nursing/Assistant Director of Nursing to ensure any medications that require monitoring with a lipid panel or thyroid stimulating hormone (TSH) are requested upon admission from the Medical Director, ordered and obtained as determined in the recommended guidelines and as deemed appropriate by the Medical Director.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

" The Director of Nursing will ensure that the Plan of Correction has been implemented by performing the following actions:
" On 3/8/24 the Nurse Consultant provided 100 % education to the Medical

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F 757	Continued From page 32 of under-treatment. It was his expectation for the facility to monitor TSH level as indicated for residents receiving levothyroxine. An attempt to conduct a phone interview with the current Consultant Pharmacist on 02/15/24 at 3:54 PM was unsuccessful. He did not return the phone call. During a phone interview conducted on 02/15/24 at 4:31 PM, the Supervisor for the Consultant Pharmacist stated TSH level should be monitored as indicated according to the published guidelines for residents receiving levothyroxine on regular basis. An interview was conducted with the Director of Nursing (DON) on 02/15/24 at 4:41 PM. She expected the facility to monitor TSH level as indicated for residents receiving levothyroxine on regular basis according to the published thyroid guidelines. During an interview conducted on 02/16/24 at 10:35 AM, the Administrator expected the facility to check TSH level for residents receiving levothyroxine as indicated to ensure all the labs were completed in a timely manner. 2. Review of the lipid guidelines published in 2019 by the American College of Cardiology and American Heart Association indicated a lipid panel should be conducted at baseline for patient receiving statin (medications used to lower cholesterol) therapy, then 4 to 12 weeks after	F 757	Director and Nurse Practitioner on ensuring labs were drawn for thyroid stimulating hormone and lipid panels for the monitoring of cholesterol levels within the recommended guidelines unless contraindicated and deemed inappropriate by the provider and documented in the medical record. " On 3/6/24 the Director of Nursing conducted 100% education to the nursing administrative team (the Assistant Director of Nursing, Staff Development Coordinator, and Unit Manager) to include agency staff, on the importance of ensuring labs for thyroid stimulating hormone and lipid panels for the monitoring of cholesterol levels were obtained as ordered by the provider within the recommended guidelines unless documented as contraindicated by the provider. The education was concluded on 3/8/24. Any administrative nursing staff member (the Assistant Director of Nursing, Staff Development Coordinator and Unit Manager) to include agency staff that is hired after 3/8/24 will receive the education during orientation prior to the start of their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Director of Nursing and the Assistant Director of Nursing will audit 5 residents labs and orders, per week x4 weeks to determine if resident□s labs for thyroid stimulating hormone (TSH) and lipid panel for the monitoring of	

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F 757	Continued From page 33 statin therapy was started or when dosage was adjusted. Afterwards, lipid panel test should be repeated once every 3 to 12 months as needed. Resident #25 was admitted to the facility on 12/28/22 with diagnoses including hyperlipidemia (high level of lipids/fats in the blood). Review of Resident #25's medical records revealed the most recent lipid panel was done on 12/22/22 when Resident #25 was in the hospital prior to being admitted to the facility. The hospital list of active medications included ezetimibe give 10 milligrams (mg) daily and atorvastatin give 40 mg at bedtime. A review of the active physician orders included to administer atorvastatin 40 mg at bedtime for cholesterol started on 12/28/22 and ezetimibe 10 mg at bedtime for cholesterol started on 12/29/22. A review of the Medication Administration Records (MAR) from January 2023 through February 2024 revealed Resident #25 received atorvastatin 40 mg and ezetimibe 10 mg at bedtime as ordered. During an interview on 02/15/24 at 10:54 AM Nurse #6 checked the active physician orders for ezetimibe 10 mg and atorvastatin 40 mg and stated both were current orders administered nightly by the nurses. An interview conducted with the Medical Records Coordinator on 02/15/24 at 1:33 PM revealed she was responsible for scanning lab test results in the electronic medical record of residents. She revealed she was unable to find a lipid panel for	F 757	cholesterol levels are ordered as appropriate and are within recommended guidelines. " The Director of Nursing or Assistant Director of Nursing will present audits to the Quality Assurance Performance Improvement Committee monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 3/15/24	

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F 757	Continued From page 34 Resident #25 after he was admitted to the facility on 12/28/22. During a phone interview on 02/15/24 at 4:12 PM the MD stated a lipid panel was obtained every six months or annually for use of atorvastatin and ezetimibe. He revealed Resident #25 was taking both atorvastatin and ezetimibe to reduce cholesterol levels and would need a lipid panel for efficacy and to check liver function due to statin use can affect the liver and he was unsure how it was missed. During a phone interview on 02/15/24 at 4:35 PM the Supervisor for the Consultant Pharmacist stated a lipid panel was a standard lab obtained when using statin medications. He revealed the most recent lipid panel obtained for Resident #25 was on 12/2022 by the hospital. An interview was conducted on 02/16/24 01:30 PM with the Director of Nursing (DON). The DON revealed a lipid panel was a routine lab and she was unsure why it was not done for Resident #25. During an interview conducted on 02/16/24 at 1:38 PM the Administrator revealed he expected the appropriate labs were obtained for the use of medications that require monitoring.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		3/15/24

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F 812	Continued From page 35 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to indicate the expiration date of thawed milkshakes in 2 of 2 nourishment rooms (Spark Unit and 100 Hall). This practice had the potential to affect beverage items served to residents. Findings included: 1. An observation of the Spark Unit nourishment room refrigerator on 02/12/24 at 3:43 PM revealed 8 thawed milkshakes sitting on a shelf. The manufacturer's instructions stamped on each carton of milkshake indicated the product was good for 14 days after being thawed. The milkshakes did not have a date indicating when they were placed in the refrigerator or when they expired. An interview with the Dietary Manager on 02/14/24 at 9:02 AM revealed dietary staff dated the milkshakes when they removed them from the walk-in freezer in the kitchen, and they were good for 14 days after being removed from the	F 812	Macon Valley -F812 Food Procurement, Store/Prepare/Serve-Sanitary Problem Statement: " On 2/12/24 and 2/13/24 it was alleged that 16 milkshakes, 8 in each nourishment room, located in both the SPARC unit and 100 hall nourishment rooms, were placed in the refrigerator without a discard date written on them. The manufacturer□s recommendation on the milkshake packaging was to discard after 14 days of being thawed. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 2/14/24, all 16 milkshakes were discarded by the Dietary Manager and the refrigerator for both the SPARC unit and 100 Hall nourishment rooms were	

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	345263	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 36 freezer. She explained the milkshakes were then placed in the nourishment room refrigerators by dietary staff. The Dietary Manager confirmed the milkshakes in the nourishment rooms had no date indicating when they were placed in the refrigerator to thaw or when they expired. An interview with the Administrator on 02/16/24 at 1:45 PM revealed he expected the milkshakes to have a pull date when they were placed in the walk-in cooler and be provided to residents as needed before the 14-day expiration date. 2. An observation of the 100 Hall nourishment room refrigerator on 02/13/24 at 3:09 PM revealed 8 thawed milkshakes sitting on a shelf. The manufacturer's instructions stamped on each carton of milkshake indicated the product was good for 14 days after being thawed. The milkshakes did not have a date indicating when they were placed in the refrigerator or when they expired. An interview with the Dietary Manager on 02/14/24 at 9:02 AM revealed dietary staff dated the milkshakes when they removed them from the walk-in freezer in the kitchen, and they were good for 14 days after being removed from the freezer. She explained the milkshakes were then placed in the nourishment room refrigerators by dietary staff. The Dietary Manager confirmed the milkshakes in the nourishment rooms had no date indicating when they were placed in the refrigerator to thaw or when they expired. An interview with the Administrator on 02/16/24 at 1:45 PM revealed he expected the milkshakes to have a pull date when they were placed in the walk-in cooler and be provided to residents as	F 812	inspected to ensure no other milkshakes were without dates. No additional undated milkshakes were noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " A 100% audit of all nourishment rooms in the facility was conducted by the Dietary Manager on 3/4/24 to ensure all milkshakes had been dated with the date they were placed in the refrigerator and any undated or expired milkshakes were removed immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " The Administrator and the Dietary Manager will ensure the Plan of Correction has been implemented by performing the following actions: " Education was conducted by the Dietary Manager and the Staff Development Coordinator for 100% of all dietary staff to on the guidelines for placing a date on milkshakes placed in the nourishment room refrigerators and following the manufacturers guidelines on the product for a date to discard. The education began on 2/28/24 and was completed the same day. Any newly hired staff will be educated by the Staff Development Coordinator or Dietary Manager during orientation and prior to the start of their first shift.	

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F 812	Continued From page 37 needed before the 14-day expiration date.	F 812	" The Dietary Manager and Administrator updated the current audit tool on 3/4/24 that is used daily to monitor the nourishment rooms to include checking for that the date the product is placed in the refrigerator to ensure it is written on any milkshakes placed in the nourishment room refrigerators. " The Administrator will review audit tools once weekly during Cardinal IDT. " The Administrator/Dietary Manager will perform walking rooms to each nourishment room weekly to spot check refrigerators and ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " The Dietary Manager/Dietary Aide will audit both nourishment rooms 5x/weekly for 4 weeks then monthly x1 month to ensure milkshakes have a date written on them to indicate the date they were placed in the refrigerator. " The Dietary Manager or the Administrator will present the audits to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of Compliance: 3/15/24	