STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 03/07/2024

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LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 03/04/24 through 03/07/24. The facility was found in compliance with CFR 483.73 Emergency Preparedness. Event ID #34GG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/04/24 through 03/07/24. Event ID #34GG11. The following complaint intakes were investigated: NC00199622, NC00214030, NC00203081, NC00203079 and NC00214152. 13 of the 13 complaint allegations did not result in deficiency.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		3/29/24

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

Electronically Signed | 03/27/2024

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to administer medications on time as prescribed by the physician for 1 of 1 residents reviewed. (Resident #7) Findings included: Resident #7 was admitted to the facility on 10/02/20. Diagnoses included, in part, schizophrenia, anxiety, dementia with behavioral disturbance, and constipation. The Minimum Data Set quarterly assessment dated 02/09/24 revealed Resident #7 was cognitively intact and received antipsychotics and antianxiety medications. An interview was conducted with Resident #7 on 03/04/24 at 1:00 PM. Resident #7 reported she did not receive her medications on time and at times the nursing staff would wake her up after 10:00 PM to administer her medications that were due at 8:00 PM. Resident #7 stated she had told the nursing staff she wanted her medications at 8:00 PM so she could go to bed and not be woken up. Resident #7 stated she had received	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 the facility failed to administer medications on time as prescribed by the physician for 1 of 1 resident reviewed. (Resident #7) 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/7/2024 Resident #7 was assessed for any adverse events related to late medication administration. Resident denied any adverse effects and no physical changes noted. On 3/7/2024 the Director of Nursing notified the medical director of late administration of medications for the following medications:	

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F 561	Continued From page 2 her 8:00 PM medications as late as 2:00 in the morning. Resident #7 stated she did not have any increased anxiety, delayed bowel movements or increased behaviors as a result of receiving the medications late, but added, she wanted them when they were scheduled. Review of the physicians' orders revealed an order written on 10/03/20 for Senna Plus 8.6-50 milligrams (mg) give 2 tablets one time a day for constipation, an order written on 10/14/21 for Risperidone (an antipsychotic) tablet 0.5 mg give one tablet at bedtime, and an order written on 07/31/23 for Klonopin (an antianxiety) 0.5 mg give one tablet two times a day for anxiety. Review of the Medication Administration Record for February 2024 revealed the medications (Senna Plus, Risperidone, and Klonopin) were all scheduled to be given at 8:00 PM. Review of the Medication Administration Audit Report for February 1 through February 29, 2024, revealed the bowel medication, the antipsychotic medication, and the antianxiety medication were administered later than 8:00 PM. The audit report indicated the scheduled time which was 8:00 PM and the administration time. The following included the dates the medications were administered late per the actual administration time: 02/01/24 medications administered at 11:41 PM by Medication Aide (MA) #5 02/03/24 medications administered at 10:30 PM by MA #1 02/04/24 medications administered at 10:04 PM by MA #1 02/06/24 medications administered at 10:04 PM	F 561	Senna Plus, Risperidone, and Klonopin that were all scheduled to be given at 8:00 PM. No new orders received. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/25/2024 the Director of Nursing completed a 72 hour look back audit for late medication administration for both day and night shift. This completed on: 3/25/2024. Results included: there were 29 of 87 residents identified with late medication administration beyond the timeframe of 1 hour prior to scheduled dose and 1 hour post the scheduled dose of medication. On 3/25/2024 the Director of nursing implemented corrective action plan to include: Interview of staff to determine reason for late administration, 1:1 Education with each identified nurse or medication aide on time management and best practice for passing medications on the unit to include completion of tool for improvement form filled out and signed by the identified staff, assessment on residents to ensure no adverse effect, and Notification to the medical provider. On 3/14/2024 the Director of Nursing audit, the medication administration orders to determine if any unnecessary orders present on the medication administration record that may be contributing factor to achievement of	

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F 561	Continued From page 3 by MA #1 02/07/24 medications administered at 10:15 PM by MA #5 02/09/24 medications administered at 12:30 AM by MA #1 02/13/24 medications administered at 10:40 PM by MA #1 02/14/24 medications administered at 12:56 AM by MA #5 02/15/24 medications administered at 1:39 AM by Nurse #4 02/17/24 medications administered at 1:46 AM by MA #1 02/19/24 medications administered at 10:27 PM by MA #1 02/20/24 medications administered at 10:50 PM by MA #1 02/22/24 medications administered at 10:58 PM by MA #1 02/24/24 medications administered at 10:32 PM by MA #1 02/27/24 medications administered at 10:49 PM by MA #1 Review of the Medication Administration Record for March 2024 revealed the medications (Senna Plus, Risperidone, and Klonopin) were all scheduled to be given at 8:00 PM. Review of the Medication Administration Audit Report for March 1 through March 6, 2024, revealed the bowel medication, the antipsychotic medication, and the antianxiety medication were administered later than 8:00 PM. The audit report indicated the scheduled time which was 8:00 PM and the administration time. The following included the dates the medications were administered late per the actual administration time:	F 561	timely medication administration. This completed on 3/22/2024. The results included there were several non-medication orders types that would benefit from placement on the treatment administration record verses the medication administration order. Corrective action was completed to remove any unnecessary orders. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/21/24 the Nurse Consultant educated the Director of Nursing and Nursing unit managers on daily Quality of Life (Monday – Friday) review of medication administration audit for review of late medication administration. Educated to review during daily clinical with immediate follow up with the nursing staff for 1:1 education and tool for improvement, interviews to determine root cause, notification to medical provider and evaluation of residents for any adverse effects. On 3/18/2024, the DON and the Registered Nurse Unit Manager began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and Medication aides to include Agency staff on F561 Self -determination related to late medication administration.	

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F 561	Continued From page 4 03/03/24 medications administered at 10:20 PM by MA #1 03/04/24 medications administered at 10:15 PM by MA #1 An interview was conducted with MA #1 via phone on 03/06/24 at 3:15 PM. MA#1 revealed she worked on the 500 hall where Resident #7 resided and the 300 hall from 7:00 PM to 7:00 AM. She stated she could not remember why she was late administering the medications to Resident #7. MA #1 added, things happen and she would fall behind. She stated she did not ask her nurse to help her when she was getting behind because she did not want to bother the nurse. MA #1 stated the medication time was 8:00 PM and the nursing staff had the flexibility to give the medications one hour before or one hour after the medications were due. MA #1 confirmed the times she gave the medications were much later than the prescribed allowable time. MA #1 stated she did not recall Resident #7 expressing to her that she wanted her medications at 8:00 PM. An interview was conducted with MA #5 via phone on 03/07/24 at 3:00 PM. MA #5 reported her routine when she came on shift was to read through the progress notes and she would start her medication pass about 8:00 - 8:30 PM. She stated she started on the 500 hall were Resident #7 resided and would usually finish about 10:00 - 10:30 PM. MA #5 stated she did not know why the medications were passed so late to Resident #7 on 02/01, 02/07 and 02/14/24. MA #5 stated Resident #7 had expressed to her to that she wanted her medications before she went to bed and not at 1:00 AM. MA #5 stated she did not	F 561	This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/25/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F561 Self Determination Quality Assurance Tool weekly x 3 weeks then monthly x 2 months or until resolved. The director of Nursing and nurse management team will review Medication Administration Audit reports for late medications daily Monday – Friday and initiate follow up to ensure improvement of nursing standards. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/29/24	

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F 561	Continued From page 5 reach out to the nurse on those nights to let her know she was behind on passing medications and she should have. An interview was attempted with Nurse #4 via phone on 03/07/24 at 11:00 AM. There was no response. An interview was conducted with the Physician on 03/07/24 at 12:10 PM. The Physician stated she would expect the nursing staff to administer the medications when they were due or within the hour before the medication was due or the hour after. An interview was conducted with the Director of Nursing (DON) on 03/07/24 at 2:30 PM. The DON reported she felt the medications aides needed to work on their time management and that the medication pass had been significantly decreased when the new physician had done an audit and discontinued several medications for several residents to decrease the medication pass time and unnecessary medications. The DON stated the medication aides were expected to start on the 500 hall and then finish on the 300 hall. She stated there were about 29 residents between the two halls and the medications aides should have been able to administer the medications at the prescribed time or no later than an hour after the prescribed time.	F 561		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		3/29/24

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F 636	Continued From page 6	F 636		

functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 7 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete comprehensive assessments within the 14-day required timeframe for 2 of 2 residents reviewed for comprehensive Minimum Data Set (MDS) assessments (Resident #290 and Resident #291). Findings included: 1. Resident #290 was admitted to the facility on 2/16/24. Resident #290's admission Minimum Data Set (MDS) dated 2/23/24 was noted as in progress as of 3/7/24. An interview was conducted with the MDS Nurse on 3/07/24 at 2:41 PM. The MDS Nurse stated the workload had increased with a lot of residents discharging and returning and she had more difficulty keeping up with the workload. The MDS Nurse stated she was aware of the timelines for completion of the MDS assessments and had	F 636	F636 – Comprehensive Assessment and Timing Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14-day timeframe was completed as follows: • Resident #290 was admitted to the facility on 2/16/2024. Admission Minimum data set assessment with Assessment Reference Date of 2/23/2024 was completed on 3/7/2024. • Resident #291 was admitted to the facility on 2/1/2024. Admission Minimum data set assessment with Assessment Reference Date of 2/8/2024 was completed on 2/21/2024. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 636	Continued From page 8 completed assessments late recently. MDS Nurse stated she was trying to get caught up. An interview with the Administrator on 3/07/24 at 3:10 PM revealed she expected that MDS assessments be completed in a timely manner. 2. Resident #291 was admitted to the facility on 2/1/24. Resident #291's 2/21/24 admission Minimum Data Set assessment was completed on 2/21/24. An interview was conducted with the MDS Nurse on 3/07/24 at 2:41 PM. The MDS Nurse stated the workload had increased with a lot of residents discharging and returning and she had more difficulty keeping up with the workload. The MDS Nurse stated she was aware of the timelines for completion of the MDS assessments and had completed assessments late recently. MDS Nurse stated she was trying to get caught up. An interview with the Administrator on 3/07/24 at 3:10 PM revealed she expected that MDS assessments be completed in a timely manner.	F 636	All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a comprehensive assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14 days timeframes. This audit will be completed by the regional Minimum data set consultant no later than 3/21/2024 • Effective 3/25/2024, the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum data set assessment Z0500 date) on that date. This has been added to the daily stand up meeting process. • Regional Minimum data set consultant will audit the current Minimum data set assessments in progress list for comprehensive assessments that are due to be completed (Minimum data set item Z0500 due date of 3/26/2024) by March 26, 2024. Facility Minimum data set coordinator with assistance of Minimum data set assessment floater will complete the identified assessments (in progress comprehensive assessments with Z0500 due date of 3/26/2024 or earlier) by March 26, 2024 Systemic Changes	

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F 636	Continued From page 9	F 636	By 3/26/2024, the Administrator or designee will complete an in-service training with the facility Minimum Data Set Coordinator that includes the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the facility's compliance with comprehensive Minimum Data Set assessments completion time frames as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled "Comprehensive Assessments and Timing Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be completed on 5 residents' completed assessments per audit and will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The	

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F 636	Continued From page 10	F 636	weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 3/29/2024	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident, staff and physician interviews, the facility failed to obtain an appointment with a retinol specialist for treatment of visual impairment for 1 of 1 residents (Resident #9) reviewed for vision. Findings included: Resident #9 was admitted to the facility on 6/8/22	F 685	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	3/29/24

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F 685	Continued From page 11 with a diagnosis which included dry eye syndrome. Review of Resident #9's electronic health record revealed a 10/17/23 vision consult which indicated Resident #9 had gradual blurry vision with the left eye greater than the right. The plan of care indicated Resident #9 was to have a referral to a retinol specialist for treatment with an appointment to be scheduled within 2-3 weeks. Review of Resident #9's electronic health record revealed a 10/17/23 optometry order form indicated a referral to a retinol specialist was required for evaluation of left eye advanced macular degeneration, a disease that causes vision loss. Review of Resident #9's 2/13/24 quarterly Minimum Data Set assessment revealed resident had adequate vision, corrective lenses were not used, and was cognitively intact. Observation of Resident #9 on 3/4/24 at 3:25 PM revealed resident sitting on the side of the bed with mail in her hands, glasses on and her call bell was activated. An interview was conducted with Resident #9 on 3/4/24 at 3:28 PM. Resident #9 stated she needed to see a vision specialist and the appointment was supposed to have been scheduled months ago. Resident #9 revealed she had trouble with vision in her left eye and was unable to see. Resident #9 indicated she activated her call bell to request assistance with reading her mail. Review of Resident #9's progress notes as of	F 685	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F685 the facility failed to obtain an appointment with a retinol specialist for treatment of visual impairment for 1 of 1 resident (Resident #9) reviewed for vision. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/6/2024 the Director of Nursing notified the primary care provider of missed referral retinol specialist. Orders received by Nurse Practitioner to schedule the appointment. On 3/6/24 the appointment was scheduled for 4/9/24 at 12:40 PM. The resident and RP were notified of the appointment. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 3/6/2024 the Director of Nurses (DON) began auditing 100% of the notes from the in-house optometry consultant for the last 6 months. This audit consisted of reviewing the optometry notes to ensure that all orders and recommendations were carried out in its entirety. Any residents whose orders were not carried out in its entirety, will have updated orders to reflect required. This audit was completed as of 03/6/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/18/2024, the Director of	

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F 685	Continued From page 12 3/5/24 revealed no evidence that the appointment with the retinol specialist was scheduled or completed. Review of Resident #9's consult notes as of 3/5/24 revealed no evidence that the resident was evaluated by the retinol specialist. Interview on 3/6/24 at 12:10 PM with the Transporter/Appointment Scheduler revealed she was in the position since September 2023. The Transporter/Appointment Scheduler stated she was responsible for scheduling appointments for the resident after she received a referral from the nurses. The Transporter/Appointment Scheduler stated she scheduled the appointments and informed the resident and family of the date and time. The Transporter/Appointment Scheduler stated she thought she recalled the Nurse Practitioner said she was waiting for the resident to be seen by the vision clinic that visits the facility. The Transporter/Appointment Scheduler stated the vision clinic only visits the facility once per year. The Transporter/Appointment Scheduler stated she did not recall receiving a referral for an appointment with a retinol specialist. Interview on 3/6/24 at 1:15 PM with the Director of Nursing (DON) revealed Medical Records received the report from the optometry appointment in October and uploaded it to Resident #9's medical record. Medical Records had not provided the Nurse Practitioner (NP) with the report for review. The DON stated the NP or physician was not made aware of the results of Resident #9's optometry appointment in October or the recommendation for the referral to a retinol specialist. The DON stated she was not aware of	F 685	Nursing and the Registered Nurse Unit manager began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) including agency staff on F685 to include treatment/Devices to Maintain Hearing/Vision. Education included to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must if necessary, assist the resident in making appointments and arrangement of transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/25/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or Designee will monitor compliance utilizing the F685 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months or until resolved.	

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F 685	Continued From page 13 the results of the appointment in October or the referral. The DON stated an appointment was made today with the retinol specialist for 4/9/24 at 12:40 PM. Interview on 3/7/24 at 10:50 AM with the physician revealed she was just made aware that the appointment with the retinal specialist had not been scheduled as ordered on the consult report. The physician stated it would not cause resident harm by not obtaining the appointment with the retinol specialist sooner, but it was a system process error.	F 685	Audits will include review of all consultations post visit reports to ensure all recommendations and referrals made. This will include auditing 6 residents on various days and shifts to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/29/24	
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	F 757		3/29/24

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F 757	Continued From page 14 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Physician interviews the facility failed to clarify a medication order prescribed for hypotension (low blood pressure) to include hold parameters if the systolic blood pressure was greater than 120 mm/hg (millimeters of mercury). This resulted in a resident (Resident #61) receiving 59 additional doses of the medication. There was no significant outcome from receiving the medication. This occurred for 1 of 3 residents reviewed for medication administration. Findings included. Resident #61 was admitted to the facility on 04/10/23 with diagnoses included in part; hypertensive chronic kidney disease with end stage renal disease, dependence on dialysis, and hypotension. A physicians order dated 05/03/23 for Resident #61 revealed Midodrine 10 milligrams (prescribed to treat hypotension which works by constricting the blood vessels causing increased blood pressure). Give 1 tablet by mouth three times a day for hypotension. Hold if systolic blood pressure is greater than 120 mm/hg. Review of the Medication Administration Record (MAR) for Resident #61 from 05/03/23 through 10/23/23 revealed Midodrine was administered as prescribed. Review of a hospital discharge summary dated	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F757 the facility failed to clarify a medication order prescribed for hypotension (low blood pressure) to include hold parameters if the systolic blood pressure was greater than 120 mm/hg (millimeters of mercury). This resulted in a resident (Resident #61) receiving 59 additional doses of the medication. There was no significant outcome from receiving the medication. Corrective action for resident(s) affected by the alleged deficient practice: For resident #61, on 3/14/2024 the facility notified the medical provider to receive clarification order for Midodrine. On 3/14/24 new order entered for Midodrine to be administered without parameters. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring medications with	

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F 757	Continued From page 15 10/27/23 for Resident #61 revealed Midodrine oral tablets 10 mg (milligrams). Give 1 tablet by mouth three times a day for hypotension if systolic blood pressure is greater than 120 mm/hg. There was no hold parameter. Review of the Medication Administration Record (MAR) for Resident #61 dated November 2023 revealed Midodrine oral tablets 10 mgs. Give 1 tablet by mouth three times a day for hypotension if systolic blood pressure is greater than 120 mm/hg. There was no hold parameter included on the MAR. Further review of the Medication Administration Record (MAR) for Resident #61 dated November 2023 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 11/01/23 a blood pressure recorded at 09:00 AM revealed 142/76 (systolic/diastolic). 11/01/23 a blood pressure recorded at 02:00 PM revealed 142/76. 11/02/23 a blood pressure recorded at 06:00 AM revealed 142/84. 11/03/23 a blood pressure recorded at 09:00 AM revealed 170/65. 11/03/23 a blood pressure recorded at 02:00 PM revealed 176/89. 11/03/23 a blood pressure recorded at 09:00 PM revealed 176/89. 11/07/23 a blood pressure recorded at 09:00 AM revealed 133/72. 11/07/23 a blood pressure recorded at 02:00 PM revealed 122/64. 11/11/23 a blood pressure recorded at 06:00 AM revealed 122/58. 11/11/23 a blood pressure recorded at 02:00 PM	F 757	parameters have the potential to be affected by this alleged deficient practice. On 3/14/2024 the Director of Nurses and nursing team began auditing all medications with parameters to ensure that orders did not require clarification. This was completed on 3/14/2024. On 3/14/2024 the Director of Nurses and nursing team completed corrective action for those residents including notification to medical provider for any clarification of orders and initiation of those orders. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/18/2024 the Director of Nurses and Registered Nurse Manager began education of all Full Time, Part Time, as needed nurses, medication aides to include agency on Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration; or Without adequate monitoring; or Without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training	

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F 757	Continued From page 16 revealed 122/58. 11/11/23 a blood pressure recorded at 09:00 PM revealed 130/79. 11/12/23 a blood pressure recorded at 02:00 PM revealed 172/95. 11/13/23 a blood pressure recorded at 06:00 AM revealed 152/97. 11/17/23 a blood pressure recorded at 02:00 PM revealed 139/66. 11/19/23 a blood pressure recorded at 02:00 PM revealed 167/105. 11/21/23 a blood pressure recorded at 02:00 PM revealed 152/78. 11/22/23 a blood pressure recorded at 06:00 AM revealed 144/72. 11/22/23 a blood pressure recorded at 04:00 PM revealed 148/78. 11/22/23 a blood pressure recorded at 09:00 PM revealed 148/78. 11/24/23 a blood pressure recorded at 04:00 PM revealed 128/70. 11/27/23 a blood pressure recorded at 06:00 AM revealed 147/84. 11/27/23 a blood pressure recorded at 04:00 PM revealed 129/78. 11/27/23 a blood pressure recorded at 09:00 PM revealed 132/86. 11/29/23 a blood pressure recorded at 06:00 AM revealed 138/78. Review of the Medication Administration Record (MAR) for Resident #61 dated December 2023 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings: 12/04/23 a blood pressure recorded at 04:00 PM revealed 141/76. 12/04/23 a blood pressure recorded at 09:00 PM	F 757	will not be allowed to work until training has been completed by 3/25/2024. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F757 Quality Assurance Tool for compliance with the Drug Regimen Review Process related to clarification of orders as part of the Daily Clinical Review Process weekly x 3 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/29/24	

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revealed 141/76.
12/06/23 a blood pressure recorded at 06:00 AM revealed 141/76.
12/06/23 a blood pressure recorded at 04:00 PM revealed 128/98.
12/08/23 a blood pressure recorded at 06:00 AM revealed 132/64.
12/08/23 a blood pressure recorded at 04:00 PM revealed 130/68.
12/11/23 a blood pressure recorded at 06:00 AM revealed 142/60.
12/13/23 a blood pressure recorded at 04:00 PM revealed 127/79.
12/13/23 a blood pressure recorded at 09:00 PM revealed 127/79.
12/15/23 a blood pressure recorded at 06:00 AM revealed 130/70.
12/20/23 a blood pressure recorded at 06:00 AM revealed 122/64.
12/20/23 a blood pressure recorded at 04:00 PM revealed 122/64.
12/27/23 a blood pressure recorded at 04:00 PM revealed 126/79.

Review of the Medication Administration Record (MAR) for Resident #61 dated January 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings:

01/01/24 a blood pressure recorded at 09:00 PM revealed 167/87.
01/03/24 a blood pressure recorded at 06:00 AM revealed 167/87.
01/05/24 a blood pressure recorded at 04:00 PM revealed 136/72.
01/08/24 a blood pressure recorded at 06:00 AM revealed 157/79.
01/08/24 a blood pressure recorded at 04:00 PM

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revealed 158/80.
01/10/24 a blood pressure recorded at 09:00 PM revealed 131/74.
01/12/24 a blood pressure recorded at 04:00 PM revealed 140/85.
01/15/24 a blood pressure recorded at 04:00 PM revealed 165/84.
01/15/24 a blood pressure recorded at 09:00 PM revealed 165/84.
01/17/24 a blood pressure recorded at 06:00 AM revealed 165/84.
01/19/24 a blood pressure recorded at 06:00 AM revealed 123/68.
01/24/24 a blood pressure recorded at 06:00 AM revealed 134/73.
01/29/24 a blood pressure recorded at 04:00 PM revealed 148/89.
01/29/24 a blood pressure recorded at 09:00 PM revealed 148/89.

Review of the Medication Administration Record (MAR) for Resident #61 dated February 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings:

02/02/24 a blood pressure recorded at 06:00 AM revealed 141/82.
02/02/24 a blood pressure recorded at 09:00 PM revealed 147/77.
02/18/24 a blood pressure recorded at 06:00 AM revealed 140/80.
02/21/24 a blood pressure recorded at 06:00 AM revealed 152/95.
02/21/24 a blood pressure recorded at 09:00 PM revealed 146/68.
02/23/24 a blood pressure recorded at 09:00 PM revealed 155/77.
02/26/24 a blood pressure recorded at 06:00 AM

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revealed 155/77.

Review of the Medication Administration Record (MAR) for Resident #61 dated March 2024 revealed Midodrine 10 mg was signed as administered to Resident #61 for the following blood pressure readings:

03/01/24 a blood pressure recorded at 4:00 PM revealed 146/87.

The Minimum Data Set quarterly assessment dated 01/31/24 revealed Resident #61 was cognitively intact. She received Hemodialysis.

During an interview with Resident #61 on 03/06/24 at 2:30 PM she indicated she was not aware of what times or dates the medication for low blood pressure was administered to her. She stated dialysis treatments took a lot out of her and she didn't feel well most days. She indicated she was not certain if receiving the Midodrine when it wasn't needed had any affect at all on her.

During a phone interview on 03/06/24 at 02:53 PM Medication Aide #1 stated she routinely provided care to Resident #61. She stated she knew Midodrine was prescribed for low blood pressure. She stated she thought she held the medication if her blood pressure was over 120 but couldn't indicate what dates the medication was held. She stated she could have held the medication although documented she gave it. She indicated if it was signed that the medication was given, then she gave the medication in error.

During an interview on 03/07/24 at 09:46 AM the Registered Nurse Supervisor stated Resident #61's order for Midodrine should have been

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clarified when it was transcribed from the hospital discharge summary on 10/27/23. She stated Resident #61 received dialysis and her medication times varied according to her dialysis schedule. She stated although her name was on the order entry following Resident #61's readmission she believed she only revised the order and was not the staff that entered the order. She could not determine who entered the initial order. She stated the Midodrine should have been clarified and hold parameters put in place but that was not done.

During a phone interview on 03/07/24 at 12:00 PM Medication Aide #2 stated she routinely provided care to Resident #61. She stated she thought she held the medication at times. She indicated if the medication was administered when it wasn't needed then it was done in error.

During a phone interview on 03/07/24 12:13 PM Medication Aide #8 stated she gave Midodrine to Resident #61 when her blood pressure was over 120 (mm/hg). She indicated that was how the order was written on the MAR.

Attempts were made to contact Nurse #1 during the investigation. Nurse #1 was an agency nurse and was on duty during the dates and times the Midodrine was administered to Resident #61. There was no response.

Attempts were made to contact agency Medication Aides #5 and #7 during the investigation. The Medication Aides were on duty during the dates and times the Midodrine was administered to Resident #61. There was no response.

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F 757	Continued From page 21 Medication Aide #6 who was on duty during the dates and times the Midodrine was administered to Resident #61 was no longer employed and no phone number was available. During an interview on 03/07/24 at 10:18 AM the Physician stated she was made aware of the Midodrine error this morning. She wrote a new order with hold parameters for blood pressures greater than 160/90. She indicated the medication was not needed if Resident #61's blood pressure was elevated. She stated the order should have been clarified and hold parameters accurate. She stated Resident #61 receiving Midodrine when it wasn't needed would have no significant effect on her and there had been no change in her condition. During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated medications were reviewed in their morning meetings. She indicated she was not aware that hold parameters were not clarified on the order for Resident #61. She stated the order was corrected today. She stated the order should have been clarified on readmission and administered per order.	F 757		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Nurse Practitioner, and Physician interviews the facility failed to follow the physicians order and provide sliding scale insulin at bedtime to a	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	3/29/24

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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 760	Continued From page 22 resident (Resident #18) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in the resident not receiving a total of 74 units of insulin from 01/12/24 through 03/04/24. There was no significant outcome. This occurred for 1 of 3 residents reviewed for medication administration. Findings included. Resident #18 was admitted to the facility on 04/11/13 with diagnoses including Diabetes Mellitus. A care plan dated 08/23/23 revealed Resident #18 had diabetes with the risk for complications. The goal of care was to adequately manage her diabetes in order to minimize the risk for complications. Interventions included in part; to administer sliding scale insulin as ordered. The Minimum Data Set annual assessment dated 02/02/24 revealed Resident #18 was cognitively intact. She required limited assistance with activities of daily living. She received insulin. A physicians order dated 01/11/24 for Resident #18 revealed Novolog Injection Solution 100 units per milliliter: Inject as per sliding scale subcutaneously before meals for diabetes for blood glucose readings as follows: 000 - 199 administer 0 units; 200 - 250 administer 2 units; 251 - 300 administer 4 units; 301 - 350 administer 6 units; 351 - 400 administer 8 units; 401 - 450 administer 10 units; 451 - 1000 administer 10 units - recheck and	F 760	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 the facility failed to follow the physicians order and provide sliding scale insulin at bedtime to a resident (Resident #18) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in the resident not receiving a total of 74 units of insulin from 01/12/24 through 03/04/24. 1. A corrective action for the resident involved On 3/7/2024 the Director of Nursing notified Nurse Practitioner for clarification order related to the Insulin sliding scale. On 3/7/2024 the Nurse Practitioner changed the order to blood sugar checks with sliding scale insulin three times a day before meals. Nurse practitioner stated no significant outcome. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who are receiving Sliding scale Insulin are at potential risk of being affected by deficient practice. Beginning on 3/14/24, the Director of Nursing / support nurses audited all current physician orders for sliding scale insulin to ensure no required clarification related to schedule dosing of insulin. This process was completed on 3/14/2024. 3. Systemic Changes	

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	345373	A. BUILDING _____ B. WING _____	C 03/07/2024

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F 760	Continued From page 23 notify the physician. A progress note dated 01/11/24 documented by the Nurse Practitioner revealed in part; plan to stabilize Resident #18's blood sugars which have been more elevated lately. Adding sliding scale insulin now four times a day in addition to her Lantus (long-acting insulin). A physicians order dated 01/12/24 revealed blood glucose checks before meals and at bedtime for diabetes please see sliding scale instructions. Review of the Medication Administration Record (MAR) for Resident #18 dated January 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 01/12/24 at 10:29 PM the blood glucose reading was 305 mg/dl no insulin administered. 01/13/24 at 08:41 PM the blood glucose reading was 253 mg/dl no insulin administered. 01/18/24 at 08:48 PM the blood glucose reading was 234 mg/dl no insulin administered. 01/19/24 at 09:03 PM the blood glucose reading was 259 mg/dl no insulin administered. Review of the Medication Administration Record (MAR) for Resident #18 dated February 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 02/03/24 at 10:42 PM the blood glucose reading	F 760	Beginning on 3/18/2024 the Director of Nursing will begin educating all full time, part time, as needed, Registered Nurse, Licensed Practical Nurse, Medication aide including agency on the following topic: F760 Residents are Free of Significant Medication error. • What is a Medication Error? • Types of medication errors? • How to Avoid Medication Errors during administration. The 6 rights. • Clarification of unclear orders helps prevent Significant Medication Errors. The DON will ensure that any of the above identified staff who does not complete the in-service training by 3/25/24 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing will monitor completion of ongoing audits for F760 weekly for 3 weeks and monthly for 2 months or until resolved. This audit will review of sliding scale insulin orders to ensure physician orders followed as indicated. Any negative findings will immediately be addressed and reviewed with the facility QA nurse consultant for interventions or additional training. Reports will be presented to the weekly	

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F 760	Continued From page 24 was 248 mg/dl no insulin administered. 02/04/24 at 10:11 PM the blood glucose reading was 235 mg/dl no insulin administered. 02/06/24 at 10:11 PM the blood glucose reading was 215 mg/dl no insulin administered. 02/07/24 at 09:18 PM the blood glucose reading was 348 mg/dl no insulin administered. 02/08/24 at 08:34 PM the blood glucose reading was 274 mg/dl no insulin administered. 02/11/24 at 09:29 PM the blood glucose reading was 203 mg/dl no insulin administered. 02/12/24 at 09:20 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/13/24 at 10:48 PM the blood glucose reading was 341 mg/dl no insulin administered. 02/15/24 at 08:44 PM the blood glucose reading was 207 mg/dl no insulin administered. 02/18/24 at 08:56 PM the blood glucose reading was 253 mg/dl no insulin administered. 02/19/24 at 10:18 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/20/24 at 10:41 PM the blood glucose reading was 204 mg/dl no insulin administered. 02/25/24 at 10:51 PM the blood glucose reading was 225 mg/dl no insulin administered. 02/26/24 at 09:55 PM the blood glucose reading was 284 mg/dl no insulin administered. Review of the Medication Administration Record (MAR) for Resident #18 dated March 2024 revealed Novolog sliding scale insulin was administered as needed before meals. Novolog sliding scale insulin was not administered at bedtime as needed for blood glucose greater than 200 mg/dl for the following: 03/03/24 at 10:26 PM the blood glucose reading was 283 mg/dl no insulin administered. 03/04/24 at 10:32 PM the blood glucose reading	F 760	Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Completion date: 3/29/2024	

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was 220 mg/dl no insulin administered.

During a phone interview on 03/06/24 at 02:53 PM Medication Aide #1 stated she worked night shift from 7:00 PM through 7:00 AM and routinely provided care to Resident #18. She stated she checked Resident #18's blood sugars two times during her shift, which were at bedtime and in the morning. She stated Resident #18 did not have orders for sliding scale coverage at bedtime and she only received insulin coverage before meals. She indicated Resident #18 was only given sliding scale insulin to cover her blood sugars when she checked her in the mornings. She stated she was not aware that sliding scale insulin was ordered at bedtime and indicated there was no space on the electronic medical record to document that insulin was to be administered at bedtime. She indicated she was not clear on the order if insulin was to be administered at bedtime. She stated as a Medication Aide she would not administer the insulin but would report it to the charge nurse anytime sliding scale insulin was ordered and the nurse would administer it. She reported that Resident #18 was not symptomatic at bedtime when her blood sugar levels were over 200 mg/dl.

During a phone interview on 03/07/24 at 12:00 PM Medication Aide #2 stated she worked night shift from 7:00 PM through 7:00 AM and routinely provided care to Resident #18. She stated she checked blood sugars two times during her shift for Resident #18 which were at bedtime and in the morning. She stated Resident #18 did not have orders for sliding scale coverage at bedtime. She stated she would have reported blood sugar readings to the nurse in charge if insulin was scheduled and the nurse would administer the insulin, but no insulin was ordered at bedtime.

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F 760	Continued From page 26	F 760		

She indicated she was not clear on the order if Resident #18 was supposed to be given insulin at bedtime.

Attempts were made to contact Nurse #1 during the investigation. Nurse #1 was an agency nurse and was on duty during the dates and times the sliding scale insulin was not administered to Resident #18. There was no response.

Attempts were made to contact Nurse #2 during the investigation. Nurse #2 was on duty during the dates and times the sliding scale insulin was not administered to Resident #18. Nurse #2 was no longer employed by the facility. There was no response.

Attempts were made to contact agency Medication Aides #3, #4, and #5 during the investigation. The Medication Aides were on duty during the dates and times the sliding scale insulin was not administered to Resident #18. There was no response.

During an interview on 03/07/24 at 10:18 AM the Physician indicated she was not aware Resident #18 was not getting sliding scale coverage at bedtime. She reported the Nurse Practitioner wrote the order for sliding scale insulin at bedtime. She stated she didn't typically like to prescribe nighttime insulin to residents due to the risk of hypoglycemia. She stated there would not be any significant outcome for Resident #18 not receiving insulin at bedtime and it was probably best that she didn't get the insulin at bedtime.

During an interview on 03/07/24 at 11:12 AM the Nurse Practitioner stated she wrote the order for sliding scale insulin in January 2024 and had

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F 760	Continued From page 27	F 760		

planned to discontinue the bedtime sliding scale insulin order after a few weeks which would be in February 2024, but she overlooked discontinuing the order. She stated it was fine that Resident #18 wasn't getting sliding scale insulin coverage for the bedtime blood sugar checks even though some of the blood sugar readings were greater than 200 mg/dl because of the risk of hypoglycemia. She stated she planned to change the order today and order blood sugar checks with sliding scale insulin three times a day before meals.

During an interview on 03/07/24 at 11: 15 AM the Registered Nurse Supervisor stated that Novolog sliding scale was ordered before meals on 01/11/24, then on 01/12/24 an order was entered for blood sugar checks before meals and at bedtime and to see sliding scale instructions for coverage. She indicated what should have occurred when the order for blood sugars before meals and at bedtime was added the entire order for Novolog sliding scale before meals should have been discontinued and Novolog sliding scale four times a day before meals and at bedtime should have been entered and that was not how it was entered. She indicated this was likely the cause of the bedtime sliding scale insulin order not being followed.

During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated medications were reviewed daily in the morning meetings. She indicated she was not aware of the insulin order not being followed for Resident #18. She stated her expectation was for staff to follow the physicians orders and indicated the sliding scale insulin was an active order and should have been followed.

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage. Findings included.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	3/29/24

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F 761	Continued From page 29 Review of the manufacturer's instructions for Lantus insulin pens revealed to discard 28 days after opening. Review of the manufacturer's instructions for Brimonidine eye drops revealed to discard 4 weeks after opening. Review of the manufacturer's instructions for Latanoprost eye drops revealed to discard 6 weeks after opening. An observation of the 300-hall medication cart on 03/04/24 at 11:30 AM along with Nurse #3 revealed two Lantus insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens. A bottle of Brimonidine eye drops and a bottle of Latanoprost eye drops were opened with no opened dates labeled on the bottles. During an interview on 03/04/24 at 11:35 AM Nurse #3 stated she was not aware the insulin pens were not dated and indicated she did administer one of the two insulin pens to the resident it was prescribed for earlier today. She stated she was new to the facility and still getting used to procedures. She acknowledged the Lantus insulin pen was not dated and stated she failed to check for an opened date prior to administering the insulin. She indicated she had not administered either of the eye drops and had not checked the bottles for opened dates. During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated insulin pens and eye drops should be labeled with opened dates when they were opened. She stated the nurse should have checked the date prior to administering the	F 761	deficiencies cited have been or will be corrected by the dates indicated F 761 the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/4/2024 Nurse #3 discarded two Lantus insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens, a bottle of Brimonidine eye drops and a bottle of Latanoprost eye drops. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/5/2024 the pharmacist audited all medication carts to ensure that all eye drops were dated when opened. All identified concerns addressed at time of discovery. On 3/5/2024 the pharmacist audited all medication carts to ensure that all Insulin pens dated, labeled and stored in the correct cylinder storage container. All identified concerns were addressed at time of discovery. On 3/5/2024 the pharmacist audited all medication carts to ensure no expired medications per the manufacturer guidelines. All identified concerns were addressed at time of discovery. On 3/5/2024 the pharmacist completed corrective action of: disposing all items of deficient practice.	

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F 761	Continued From page 30 insulin. She stated education would be provided.	F 761	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/18/2024 the Director of Nurses and Register Nurse Manager began education of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included safely securing and storing medications, labeling of the date on opened insulin pens and checking expiration dates on medications to assure no expired medications are administered. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/25/2024. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee for F761 Adequate Label/Store Drugs and Biologicals to assess that all medications are safely and appropriately stored, that all medications are dated and labeled when opened. Audits will be completed weekly x 3 and monthly x 2 or until resolved for compliance with this	

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F 761	Continued From page 31	F 761	process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality assurance Meeting is attended by the Administrator, Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 3/29/24	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §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.	F 867		3/29/24

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F 867	Continued From page 32 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

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safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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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 867	Continued From page 34 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint survey of 7/30/21 and the recertification and complaint survey of 11/21/22. This was for one deficiency that was originally cited in July 2021 in the area of significant medication errors and for two deficiencies originally cited in November 2022 for medication storage and unnecessary medications. These deficiencies were subsequently recited on the current recertification survey of 03/07/24. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to:	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: The Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the	

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	345373	A. BUILDING _____ B. WING _____	C 03/07/2024

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F 867	Continued From page 35 F757: Based on observations, record review, staff, and Physician interviews the facility failed to clarify a medication order prescribed for hypotension (low blood pressure) to include hold parameters if the systolic blood pressure was greater than 120 mm/hg (millimeters of mercury). This resulted in a resident (Resident #61) receiving 59 additional doses of the medication. There was no significant outcome from receiving the medication. This occurred for 1 of 3 residents reviewed for medication administration. During the recertification and complaint survey of 11/21/22 the facility administered a medication to a resident that was not medically justified. An interview was conducted with the Administrator on 03/07/24 at 3:30 PM. The Administrator stated she believed the QA process needed to be more focused on clarifying orders and reviewing all medications daily for accuracy and following the parameters. F760: Based on observation, record review, staff, Nurse Practitioner, and Physician interviews the facility failed to follow the physicians order and provide sliding scale insulin at bedtime to a resident (Resident #18) when the blood glucose reading was greater than 200 mg/dl (milligrams per deciliter). This resulted in the resident not receiving a total of 74 units of insulin from 01/12/24 through 03/04/24. There was no significant outcome. This occurred for 1 of 3 residents reviewed for medication administration. During the recertification and complain survey of 07/30/21, the facility failed to administer intravenous (IV) medication as ordered by the physician.	F 867	recertification and complaint survey of 7/30/21 and the recertification and complaint survey of 11/21/22. This was for one deficiency that was originally cited in July 2021 in the area of significant medication errors and for two deficiencies originally cited in November 2022 for medication storage and unnecessary medications. These deficiencies were subsequently recited on the current recertification survey of 03/07/24. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: F761 Label/Store Drugs and Biologicals. Corrective action has been taken for the identified concerns in the area of: F760 Residents free of Significant medication errors. Corrective action has been taken for the identified concerns in the area of: F757 Drug regimen free from unnecessary drugs. Corrective action has been taken for the identified concerns in the areas of: F867 The Quality Assurance Performance Improvement (QAPI) committee held a meeting on March 19, 2024 to review the deficiencies from the recertification and	

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F 867	Continued From page 36 An interview was conducted with the Administrator on 03/07/24 at 3:30 PM. The Administrator stated she believed the QA process needed to be more focused on clarifying orders and reviewing all medications daily for accuracy and following the parameters. F761: Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage. During a recertification and complaint survey of 11/21/22 the facility failed to: accurately label and record an opened date on a bottle of tuberculin solution and a bottle of Influenza vaccine; accurately record an opened date on a bottle of eye drops and insulin pens; dispose of expired bottles of nitroglycerin, insulin pens, and bottle of nasal spray; lock and secure a medication cart in an unattended resident care area; and to securely store medication on a medication cart. An interview was conducted with the Administrator on 03/07/24 at 3:30 PM. The Administrator revealed the facility including the pharmacist and the Director Nursing believed that the problems with medication storage were related to the inconsistency of the staff on the 300 and 500 halls. The Administrator stated two new nurses were hired to be consistent floor nurses for the two halls.	F 867	complaint survey of July 30, 2021 and the recertification and complaint survey of November 21, 2022 and recertification survey of March 7, 2024 reviewed the citations. On March 21, 2024, Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/21/2024, the Administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/25/2024.	

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F 867	Continued From page 37	F 867	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/29/24	