STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 09/11/2024

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LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/8/24 through 9/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 0T3K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/8/24 through 9/12/24 Event ID# 0T3K11. The following intake was investigated NC00216800. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		10/2/24

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

Electronically Signed | 10/02/2024

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F 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and resident interviews the facility failed to maintain resident areas and equipment in a safe and sanitary manner for 2 of 3 shower (Shower room #2 on the 200 hall, Shower room #3 on the 300 hall), clean wheelchairs for 4 of 7 Resident's wheelchairs (Resident #24, Resident #132, Resident # 64, and Resident #3), and repair a wall behind the bed (room 309 bed A) for 1 of 10 rooms reviewed for environmental concerns. The findings included: 1a. On 09/09/24 at 3:38 PM the entrance door of the 200 hall shower room #2 was propped open.	F 584	F584 E Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Wheelchairs – On 9/11/2024 Housekeeper cleaned the wheelchairs for residents: #24, #132, #64 and #3. Shower Room #2 – On 9/10/2024 the item used to prop the shower door was removed. The housekeeper for 200 Hall cleaned and disinfected the shower room allowing the rancid odor to dissipate. On 9/11/2024 the Environmental Services (EVS) Manager and Maintenance	

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F 584	Continued From page 2 Upon entering the shower room, a rancid odor permeated the entire shower room causing the surveyor to feel nauseous until the morning of 09/10/24. On the left side wall of the shower room where the sink was located a white ceramic toothbrush holder on the right side of the sink was loosely attached to the tile wall. The round floor drain cover located in the center of the shower room floor was observed with unidentified debris and hair covering more than half of the floor drain cover. An observation of the tiled wall dividing the shower stall and bathtub area revealed the lower right side of the divider wall had 5 cracked, jagged edged tiles. The plastic corner guard, which would have covered the cracked, jagged edged tiles, was observed on the floor at the back of the shower stall. Observation of the tiles and grout on the surrounding walls and floor of the shower stall revealed thick dark-brownish black dirt and debris at the joints of the wall and floor tiles. Upon closer inspection it was revealed there were 2 missing tiles on the shower room floor that measured 1 inch x 1 inch. The round drain cover located on the floor of the shower stall was covered with thick gray debris and visible hair. b. On 09/09/24 at 4:08 PM an observation of the shower room #3 on the 300 hall revealed there was no trash can liner in the trash can, and trash was observed on the floor around the trash can. A white ceramic toothbrush holder to the left of the sink was observed loosely fastened to the wall. The left faucet handle of the sink was observed without the top cover and the exposed inside screw was covered with rust. The shower stall area next to the bathtub revealed a silver nail clipper and soiled washcloth on the floor. The inside tiles and grout on the surrounding walls and floor of the shower stall revealed thick	F 584	Assistant addressed following: tightened the toothbrush holder; cleaned the shower room floor and shower stall floor drain; replaced the corner guard in order to cover the jagged tiles on the divider wall. EVS Manager submitted a work order for the missing floor tiles to be replaced. On 9/11/2024 Housekeeper for 200 Hall cleaned the shower room to include using a Clorox solution to remove the thick, dark-brownish black dirt and debris at the joints of the wall and floor tiles. Shower Room #3 – On 9/10/2024 the housekeeper for 300 Hall placed a liner in the trash can, discarded the silver nail clipper and removed the soiled washcloth. On 9/11/2024 the housekeeper for 300 Hall cleaned the shower room to include using a Clorox solution to remove the thick, dark-brownish black dirt at the joints of the wall and floor tiles. Wall Damage – 309A – On 9/11/2024 Maintenance Assistant replaced the wall guard at the head of the bed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/11/2024 Administrator checked 400 Hall shower room and did not find additional occurrences of cleaning or maintenance issues. On 9/12/2024 EVS Manager completed an audit of all resident rooms to identify damaged walls that required a repair. EVS Manager and Administrator developed a working list of repairs and an order for the Maintenance Assistant to complete them. Repairs will be prioritized into three	

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F 584	Continued From page 3 dark-brownish black dirt and debris at the joints of the wall and floor tiles. 2a. On 09/09/24 at 4:16 PM an observation of the wheelchair of Resident #24 revealed crumbs of dried food debris on the seat cushion, and dried spill marks were observed in the wheelchair arm side pieces. The wheelchair frame and wheel spokes were observed covered with a layer of thick gray dust. b. The wheelchair that belonged to Resident #132 was observed on 09/09/24 at 4:16 PM and revealed the frame and wheel spokes covered with a layer of thick gray dust. c. On 09/09/24 at 4:18 PM an observation of the wheelchairs that belonged to Resident # 64 and Resident #3 revealed food crumbs on both wheelchair seats and the frames and wheel spokes of both wheelchairs were covered with a layer of thick gray dust. On 09/10/24 at 1:42 PM an environmental tour was conducted with the Administrator and included an observation of shower room #3 on the 300 hall, and shower room #2 on the 200 hall. There was a faint, rancid smell detected from shower room #2 on the 200 hall. The Administrator revealed during the tour, the shower rooms needed repair and cleaning. The Administrator observed the wheelchairs of Resident #64 and Resident #3 and revealed the nurse staff on the night (11:00 PM - 7:00 AM) Monday through Friday. On 09/10/24 at 2:14 PM the wheelchair cleaning schedule was reviewed and revealed each room with a wheelchair, including the wheelchairs of	F 584	categories. Urgent referring to within seventy-two hours. Immediate referring to between three and fourteen calendar days and Routine referring to between forty-five and sixty days. 18 rooms were identified requiring repairs. 4 required urgent repairs and 13 required immediate repairs. EVS Manager and Maintenance Assistant will work to correct repairs according to the prioritization schedule. Repairs that cannot be performed by the EVS Manager or Maintenance Assist will be referred to a contractor. Administrator and EVS Manager will review the list every two weeks for completion of work and to make necessary adjustments. On 9/12/2024 – CNAs and nursing administrative staff (DON, Assistant DON and RN Supervisor) inspected all resident wheelchairs in use for cleanliness. Facility CNAs spot cleaned those that required immediate attention this was completed on 9/12/2024. Those wheelchairs needing to be pressure washed were placed on monthly pressure washing that began on 9/28/2024. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 9/25/2024 the Environmental Services (EVS) Manager educated all housekeeping staff on cleaning procedures for shower rooms to include effective disinfectant solutions. Housekeeping staff received additional instructions to report any damaged wall areas by submitting a maintenance work	

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F 584	Continued From page 4 Resident #24, Resident #132, Resident #64, and Resident #3, were to be cleaned monthly on night shift. Review of work orders revealed no concerns reported related to shower room cleanliness or wheelchair cleaning. Wheelchairs that were assigned to be cleaned were observed in the assignment book. There was no documentation to confirm if wheelchairs were cleaned or not. On 09/11/24 at 7:29 AM Nurse #2 was interviewed. Nurse #2 revealed that she worked the night shift when the Nursing Assistants (NAs) were scheduled to clean wheelchairs as scheduled posted in the assignment books. Nurse #2 revealed 4 wheelchairs were scheduled to be cleaned every night and there was no place to document if they were cleaned or not, but she had never received a report that wheelchairs had been cleaned or not cleaned. On 09/11/24 at 7:45 AM an interview with Housekeeper #1 was conducted and revealed she was assigned to clean the 200 hall shower room, shower room #2 and sometimes left the door propped open to dry the floor after it was mopped. Housekeeper #1 revealed she did smell an odor in the shower room #2 on the 200-hall and believed the odor was from the trash and the soiled linen bins. Housekeeper #1 revealed if she had any concerns about any room, she was assigned to clean she would have notified her manager. Housekeeper #2 interviewed at 7:52 AM on 09/11/24 revealed she was assigned the 200 hall and 300 hall shower rooms, shower rooms, #2 and #3, she had not smelled any strong odors in either of them and had not noticed the cracked	F 584	order. On 9/25/2024 Director of Nursing (DON) educated facility appointed Certified Nursing Assistant (CNA)/Housekeeper on wheelchair cleaning process and monthly pressure washing process for wheelchairs. On 9/25/2024 the Staff Development Coordinator (SDC) educated all direct care staff on ensuring shower rooms are cleaned to include removing debris and clutter after use and cleaned between residents. On 9/25/2024 the SDC educated all direct care staff on the wheelchair cleaning schedule process and the monthly pressure washing process. Additionally, education on reporting wheelchair cleaning was provided. Education included facility certified nursing assistants on night shift are responsible for cleaning wheelchairs according to the wheelchair cleaning schedule. Nursing assistants must initial wheelchair cleaning sheet and turn in to supervising nurse. Wheelchair cleaning sheets are then turned into the Director of Nursing. Nursing staff was also educated on identifying and reporting wheelchairs in need of pressure washing. On 9/25/2024 Administrator educated EVS Manager and Maintenance Assistant on routine rounding and periodic room checks to ensure areas in resident rooms and facility shower rooms needing repair have been identified, communicated and addressed in a timely manner. Education further included that each shower room is deep cleaned monthly.	

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F 584	Continued From page 5 tiles or concerns with the privacy curtains because she would have verbally reported any concerns to her manager. An interview with Nurse Assistant (NA) #1 who worked the night shift was conducted on 09/10/24 09:25 AM. NA #1 revealed she knew there was a wheelchair cleaning schedule in the daily assignment book. She reported the staff tried to clean as many wheelchairs as scheduled but were not always able to get to them all and there was nowhere to document if they had been cleaned or not. An observation and interview conducted with the Maintenance Director on 09/11/24 at 10:43 AM of the 200 hall shower room revealed he did not check the shower room frequently for maintenance concerns or housekeeping concerns. The Maintenance Director revealed he knew the shower room needed repairs and multiple items needed to be replaced. He also revealed he did notice a foul odor from shower room #2 on the 200 hall shower room at times and believed the odor came from either stagnant water in the drain system or dirty water clogged the drains. There was a faint odor of the rancid smell detected on the observation on 09/09/24, in shower room #2. The Maintenance Director revealed he had previously smelled an odor that was stronger than it was during our tour. The physical structural and cleanliness issues identified on 09/09/24 at 3:38 PM were also found during the observation with the Maintenance Director . On 09/11/24 at 1:40 PM a follow up interview with the Administrator was conducted and he revealed all shower rooms were expected to be clean,	F 584	Beginning 9/25/2024 Administrator educated the administrative staff (DON, Assistant Director of Nursing/Staff Development Coordinator, RN Supervisor, EVS Manager and other department directors) on routine rounding to ensure facility maintains a safe, clean, comfortable and homelike environment in the areas of equipment cleanliness; ensuring shower rooms are deep cleaned monthly and damaged walls in resident care areas are reported timely within 72 hours. The facility specific education for the above identified staff members was completed 10/1/2024; any of the above identified staff who does not receive the above training by 10/1/2024 will be not allowed to work until they have received the training. This information has been integrated into the standard orientation training and in the required education refresher for all staff identified above and will be reviewed by the quality assurance process to verify that the change has been sustained. On 9/27/2024 all of the above identified areas and results of audits were reviewed and discussed during the weekly quality assurance and process improvement (QAPI) meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning the week of 10/7/2024 the Administrator or designee will monitor the wheelchair cleaning schedule and spot check one random wheelchair from the schedule for cleanliness; monitor each	

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F 584	Continued From page 6 neat, and orderly, and wheelchairs were to be cleaned as per the schedule. 3. Room 309 bed A was observed on 9/8/24 at 3:53 PM. Resident #1 was in bed and her family members were at the bedside. Behind the bed, the wall had streaks of dried adhesive, and the drywall had gouges, and the paint appeared to be rubbed off in spots. Resident #1's family members were interviewed during the observation, and they reported the plastic wall protector had fallen off the wall "a while ago" and that they had placed the sheet of plastic beside the bed A closet. The sheet of wall protector was brittle and discolored yellow. The family members explained they had reported the plastic wall protector sheet had come off the wall to a staff member. The family members were unable to recall the name of the staff member. The family members said they had been told Room 309 was scheduled to be repainted over a year ago. Nursing assistant (NA) #1 was interviewed on 9/10/24 at 9:25 AM and she reported if she noticed repairs needed completed, she filled out a work order and put in in the maintenance department mailbox. NA #1 explained she had not noticed the wall behind 309 bed A needed repaired. NA #2 was interviewed on 9/10/24 at 9:38 AM. NA #2 reported she filled out a work order for repairs, or she verbally notified the maintenance department. An interview was conducted with Nurse #1 on 9/10/24 at 10:01 AM. Nurse #1 reported she was	F 584	shower room for cleanliness and operating condition and monitor one room on each (4) hall to ensure that rooms are clean and free of visible wall damage. This monitoring will be completed five times per week for two weeks; then weekly for two weeks; then monthly for two months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or 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, indefinitely or until no longer needed for wheelchair cleaning and environmental issues. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Rehab Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager. Compliance Date: October 2, 2024.	

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F 584	Continued From page 7 usually assigned to the 300 hall, but she had not noticed the wall behind bed A in room 309. The nurse explained if repairs need to be made, she filled out a work order and placed it in the maintenance department mailbox. An observation of Room 309 with the maintenance director occurred on 9/11/24 at 10:46 AM. The maintenance director reported he was not aware of the condition of Room 309 bed A's wall, and he reported his assistant was responsible for completing work orders on resident rooms. The maintenance assistant was interviewed on 9/11/24 at 11:02 AM during an observation of Room 309. The maintenance assistant reported he was not aware of the condition of the wall behind bed A, and he had not received a work order for repairs. The maintenance assistant explained he would have replaced the plastic wall protector sheet and repaired the walls behind bed A. Work orders for the facility were reviewed and there were no work orders for Room 309 bed A. The Administrator was interviewed on 9/11/24 at 2:07 PM and he reported he expected the resident rooms to be clean and in good repair with maintenance completing repairs as quickly as possible. The Administrator reported he expected nursing staff to use a work order form to report repairs to the maintenance department.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F 637		10/2/24

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F 637	Continued From page 8 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a comprehensive significant change in status Minimum Data Set (MDS) assessment for 1 of 7 residents (Resident #11) reviewed for significant change in condition. The findings included: Resident #11 was readmitted to the facility on 08/26/24 with diagnoses that included urine retention and chronic kidney disease. A review of hospital discharge note dated 08/26/24 revealed in part Resident #11 had a urinary tract infection and a wound to her sacrum. Review of a readmission skin assessment dated 08/26/24 revealed in part that Resident #11 had a stage 3 pressure ulcer of the sacrum. A review of a nurse progress note dated 8/27/24 at 10:24 AM revealed in part that Resident #11 had a urinary catheter. A weight loss note dated 08/28/24 at 12:20 PM	F 637	F637 Comprehensive Assessment after Significant Change Corrective Action Minimum Data Set (MDS) assessment for affected resident that was identified was not completed within the required timeframe and said resident has since expired. Resident #11 Comprehensive Assessment after Significant change set with Assessment Reference date (ARD) 08/30/2024 was completed in error as a quarterly OBRA assessment. The significant change assessment was not identified and completed within the required 14 days. On 10/1/2024, the Regional Nurse Consultant conducted in-service training for the facility Minimum Data Set (MDS) Nurse on the importance of scheduling and completing a Minimum Data Set (MDS) assessment for all residents with the specified time frame per chapter 2 page 22 of the Resident Assessment Instrument (RAI) manual. The education emphasized that all	

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F 637	Continued From page 9 revealed that Resident #11 had a weight loss of 10% or greater in the last 180 days. A quarterly MDS assessment dated 08/30/24 included in part that Resident #11 had severe cognitive impairment, she was always incontinent of bladder and bowel, had no weight loss or weight gain and was at risk to develop pressure ulcers. The MDS Coordinator was interviewed on 09/11/24 10:46 AM she revealed she missed coding those areas and should have completed a significant change in status MDS assessment for Resident #11 upon her readmission. On 09/11/24 at 1:40 PM an interview with the Administrator revealed he expected significant change MDS assessments be completed in a timely manner.	F 637	residents must have a Comprehensive Assessment after Significant Change completed within 14 days of noted significant change. A significant change is a major decline or improvement in a resident□s status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the president□s health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Chapter 2, page 22 of the Resident Assessment Instrument Manual (RAI). Focus was also placed on the importance of ensuring that all Minimum Data Set (MDS) assessments be completed, encoded and transmitted within the required timeframes as set forth by Centers for Medicare and Medicaid Services (CMS) as stated in Chapter 2 of the Resident Assessment Instrument (RAI) Manual. Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 10/1/2024, the Clinical Reimbursement Consultant conducted an audit for timely completion of Significant Change Assessments within the last 90 days utilizing the Centers for Medicare and Medicaid (CMS) final validation reports. The audit reviewed the Minimum Data Set (MDS) assessments for completion dates not more than 7 days	

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F 637	Continued From page 10	F 637		

from the Assessment Reference Date (ARD) and the Care Area Assessment (CAA) completion date not more than 14 days. The results of this audit were:
5 Comprehensive Assessments were identified and reviewed utilizing a 90-day lookback.
2 Significant Change Assessments were identified with 1 submitted timely and 1 submitted late
3 Annual Assessments were identified with 2 submitted timely and 1 submitted late

Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur.
On 10/1/2024, the Clinical Reimbursement Consultant conducted in-service training for the facility Minimum Data Set (MDS) Nurse on the importance of scheduling and completing a Minimum Data Set (MDS) assessment for all residents with the specified time frame per chapter 2 page 22 of the Resident Assessment Instrument (RAI) manual. The education emphasized that all residents must have a Comprehensive Assessment after Significant Change completed within 14 days of noted significant change.

Monitoring
The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements;
Beginning the week of 10/7/2024, the

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	345503	A. BUILDING _____ B. WING _____	C 09/11/2024

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LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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F 637	Continued From page 11	F 637	Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 3 months to validate whether or not they have had a Significant Change with a Minimum Data Set (MDS) assessment completed timely per the Resident Assessment Instrument (RAI) Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled Comprehensive Assessment after Significant Change. This will be done on a weekly basis for 4 weeks then monthly for 2 months. 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 weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 10/2/2024	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		10/2/24

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F 658	Continued From page 12 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide care according to professional standards when Unit Manager #1 failed to ensure Resident #50 swallowed her medications prior to leaving her room and was observed with a pill lying on her chest, and Resident #13 was observed to have a medicine cup with pills left unattended on her bedside table. The deficient practice occurred for 2 of 2 residents reviewed for professional standards (Resident #50 and Resident #13). The findings included: 1. Resident #50 was admitted to the facility 4/23/24 with diagnoses that included cerebral infarction (stroke) and gastrostomy. A review of Resident #50's physician orders revealed an order dated 5/20/24 for Tramadol 50 milligrams (mg) one tablet by mouth every 8 hours. The physician orders further revealed Resident #50 was able to swallow medications whole and all her pills were ordered to be administered by mouth. The quarterly Minimum Data Set (MDS) dated 7/26/24 indicated Resident #50 had severe cognitive impairment. An observation conducted on 9/8/24 at 5:48 PM revealed Resident #50 was lying in bed talking but her speech was unclear and there was no one else in her room. Resident #50 was further observed to have a white oblong pill lying on the	F 658	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. F 658 Services Provided Meet Professional Standards Corrective action for resident(s) affected by the alleged deficient practice For resident #50- On 9/8/2024, Unit Manager# 1 assessed resident with no new complaints of pain or acute distress identified and notified the MD and order given to re-administer medication crushed. Unit Manager #1 administered medication as ordered. On 9/9/2024, the Director of Nursing completed medication pass observation with Unit Manager #1 with no issues identified For resident # 13- On 9/9/2024, Resident assessed by Director of Nursing w/ no acute distress noted. Medication removed from resident□s #13 room and discarded by nurse #3. MD notified and order given to re-administer medications as ordered. Nurse #3 administered medication as ordered.	

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F 658	Continued From page 13 right side of her chest that was dry and intact. An interview conducted with Unit Manager #1 on 9/8/24 at 6:00 PM indicated Resident #50 was able to swallow her medications whole and they were ordered to be administered by mouth. Unit Manager #1 revealed she gave Resident #50 one tablet of Tramadol 50mg at 4:42 PM. She stated she placed the pill in Resident #50's mouth and watched her swallow 5 to 6 sips of water indicating to her she also swallowed the pill. Unit Manager #1 revealed she could not explain why the pill was found on Resident #50's chest but she must have spit it out after she left her room. An interview was conducted with the Director of Nursing (DON) on 9/9/24 at 9:41 AM. She stated Resident #50 was able to take her medications by mouth and she was not aware of any concerns related to her pocketing or spitting out pills. The DON further stated Unit Manager #1 should have confirmed Resident #50 swallowed her medication before leaving her room. 2. Resident #13 was admitted to the facility 4/27/21 with diagnoses that included type 2 diabetes and chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 6/24/24 indicated Resident #13 was cognitively intact. A review of Resident #13's 9/9/24 active physician orders revealed orders for citalopram hydrobromide 20 milligrams (mg) one tablet by mouth once daily, potassium chloride extended release 20 milliequivalent two tablets by mouth once daily, amlodipine besylate 5mg one tablet by mouth once daily, bupropion hydrochloric acid	F 658	Corrective action for residents with the potential to be affected by the deficient practice On 9/12/2024 the Director of Nursing completed a 100% audited all current resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no other residents who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. Additionally beginning 9/9/2024, the Director of Nursing completed random medication pass observation for nurses to ensure medications administered as ordered and residents ingested all administered meds. No issues noted with medication pass observations. This was completed on 9/12/2024. On 9/27/2024 all of the above identified areas and results of audits were reviewed and discussed during the weekly quality assurance and process improvement (QAPI) meeting. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning 9/25/2024, the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses including agency staff on the following topics: Medication Administration and Professional Standards including the importance of ensuring medications are not left at the bedside and to ensure all medications being administered are ingested by resident. The Director of	

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F 658	Continued From page 14 (HCL) 75mg one tablet by mouth once daily, acetaminophen extra strength 500mg two tablets by mouth twice daily, metoclopramide HCL 5mg one tablet by mouth twice daily, torsemide10mg one tablet by mouth twice daily and lorazepam 0.5mg one half tablet by mouth twice daily. An observation conducted on 9/9/24 at 9:48 AM revealed Resident #13 was in her bathroom with the door closed. Further observation of Resident #13's room revealed a medicine cup was left unattended on her bedside table which contained two large oblong white pills, one round dark orange pill, four round white pills, one round orange pill, one small oblong white pill, and half of a round white pill. An interview conducted with Nurse #3 on 9/9/24 at 10:06 AM revealed she went to Resident #13's room to administer her morning medications but Resident #13 had to use the bathroom. She indicated she placed Resident #13's medications on the bedside table and then left the room. Nurse #3 stated she should have waited for Resident #13 to return from the bathroom to administer the medications and they should not have been left unattended on the bedside table. An interview was conducted with the Director of Nursing (DON) on 9/9/24 at 9:41 AM. She stated nurses should ensure a resident takes their medications prior to leaving the room and medications should not be left unattended at the bedside.	F 658	Nursing will ensure that any licensed Nurse who has not received this training by 10/1/2024 will not be allowed to work until the training is completed. 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. 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. On Beginning the week of 10/7/2024, the Director of Nursing or designee will monitor compliance utilizing the QA Tool F 658 Professional Standards. Observation will include observing medication pass for 5 residents weekly x 4 then monthly x 2 to ensure medications are administered as ordered, and not left at bedside. The ongoing auditing program will be reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary for compliance. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/2/2024	