STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 11/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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E 000	Initial Comments An unannounced Recertification/Complaint survey was conducted on 11/03/19 through 11/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZFOL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/03/19 through 11/06/19. Event# ZFOL11. 2 of the 11 complaint allegations were substantiated but did not result in a deficiency. 2 of the 11 complaint allegations were substantiated resulting in deficiencies. 7 of the 11 complaint allegations were not substantiated.	F 000		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a	F 573		11/30/19

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

Electronically Signed | 11/26/2019

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F 573	Continued From page 1 copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and record reviews the facility failed to provide a resident's Responsible Party (RP) a copy of his medical records after a they were requested for 1 of 1 resident reviewed for medical records access. (Resident #136) Findings included: Resident #136 was admitted 04/06/2017 with	F 573	F 573 Medical Records An Ad Hoc QAPI Committee meeting was held on 11/7/2019 and a root cause analysis was completed in regards to the Medical Records denial for Resident # 136 to the identified Responsible Party (RP) while Resident #136 was a resident in Cary Health and Rehabilitation. The RP who had been previously identified as next of kin in the Medical Record; was	

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F 573	Continued From page 2 diagnoses including Hypertension, Parkinson's Disease, Depression and Non-Alzheimer's Dementia. The quarterly Minimum Data Set (MDS) dated 04/01/2019 had Resident #136 coded as cognitively impaired needing extensive assistance with activities of daily living (ADL). The MDS dated 05/23/19 coded Resident #136 as having a death in the facility. A review of the Admission Agreement dated 4/6/17 read: This agreement made this 6 day of 4, 2017, by and between Cary Health and Rehabilitation Center (center) and Resident #136 (patient) previously residing (street address and post office box) and daughters name (hereafter Resident Representative). The Admission Agreement was signed and initialed by the Daughter in areas listed as the RP. The Admission Record was reviewed and listed his daughter as his RP and emergency contact #1. A review of the policies and procedures dated 7/30/2018 read: Procedure: I. Processing a request. #2. If a current resident, former resident or legal representative comes into the center to request medical records a consent for obtaining medical information form should be filled out to document the request. A review of the request for consent to obtain medical information dated 5/28/19 read: I hereby authorize Cary Health and Rehab to release copies of the medical records of the above referenced individual to: RP. This information will be used for litigation against a third party.	F 573	contacted on November 25, 2019 and November 26, 2019 via phone with a message left that the Medical Records could be picked up at the facility for Resident #136 . A letter was sent on 11/26/2019 that the medical records were ready for pick up at the facility for resident #136□'s identified next of kin. The Administrator conducted a Quality Review of Medical Records requests on 11/20/2019 for 9/1/2019-11/20/2019 there were no requests from an RP for Medical Records. Medical Records requested for Health Care Continuity or by Responsible Party were granted and sent to the identified Person or Company. The Administrator provided re-education to the Medical Records department and the Quality Assurance Performance Improvement (QAPI) Committee on 11/7/2019 regarding the process for Medical Records requests by person (s) identified as next of kin. The QAPI Committee usually consists of the Administrator, Medical Director (at least quarterly), Director of Clinical Services, Assistant Director of Nursing, MDS RN & LPN Coordinator Unit Coordinators/ Managers, Social Worker, Activities Director, Medical Records, Dietary Manager, Maintenance Director, Central Supply/ C NA, Pharmacy Consultant (at least Quarterly). An Ad Hoc QAPI Committee meeting was held on 11/22/2019 with the Divisional Clinical Quality Specialist to discuss and review systemic changes to the Medical Records request process. Quality Monitoring will be conducted by the	

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F 573	Continued From page 3 During an interview with Resident #136's Daughter on 11/6/19 at 12:07 PM, the Daughter stated she was her fathers RP and she signed his paperwork when he was admitted. The facility knew she was the RP and there was not a question about it. The daughter also stated she was the one the facility would call if there was any change in her father's health status and they needed her permission to change any care for him. The daughter further stated she came in on 5/28/19 to fill out paper work for her fathers' medical records and later, was told she was denied access to them because she needed more paperwork and she did not feel they should have denied her access to her fathers medical records. During an interview with Medical Records Coordinators (MRC) 11/05/19 at 11:15 AM, the MRC stated they have them sign a consent form and it is scanned in to legal and if resident is still here, they can receive the records in 24 and if discharged they have 30 days to release the records. There is a charge per page 1-25 pages is 75 cent a page, 26-100 is 50 cent a page, 101 and up is 25 cents a page. The MRC stated she was familiar with the resident and his daughter requested Resident #136's medical records after he passed. A family member came before he passed and requested but they were not the responsible party, so they were denied. The resident's daughter was his RP and she came after he passed away to request his records. She filled out the paper work and it was sent to legal and even though she was his responsible party, she did not have the proper paperwork to receive his medical records but had told her, she could still get the records, if she could produce the needed paperwork. The MRC stated she checked	F 573	Administrator/designee utilizing a Quality Improvement Monitoring tool to monitor Medical Records requests to ensure process for Medical Records release is implemented. The monitoring will be weekly x 4 weeks, then monthly x 2 months and then quarterly or as needed. Results of monitoring will be reviewed at the monthly QAPI Committee meeting. Monitoring will be adjusted based on findings. Date of compliance 11/30/2019.	

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F 573	Continued From page 4 that the responsible party did not have the authoritative documents on the record request that caused the residents responsible party to be denied the medical records because that was how she was trained. During an interview with the Administrator on 11/05/19 at 12:03 PM, the Administrator stated if a responsible party requests the medical records for their next of kin and in the required time frame, it should be released to them when requested plus a small fee for each page.	F 573		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		11/30/19

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F 585	Continued From page 5	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 6 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide a written grievance outcome summary to the resident and/or family for 1 of 1 sampled resident reviewed (Resident #72). Findings included: Resident #72 was admitted to the facility on	F 585	F585 Grievances An Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 11/7/2019 to review the current grievance process, root cause analysis, and discuss changes necessary for a new process. The QAPI Committee members usually consists of Medical Director (attends	

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F 585	Continued From page 7 03/09/17 with diagnoses of end stage renal disease, hypertension, chronic obstructive pulmonary disease, atrial fibrillation, anemia, and syncope. Resident #72 Minimum Data Set (MDS) dated 10/09/19 indicated the resident was cognitively intact and required extensive assistance with bed mobility and dressing. Resident #72 was assessed as total dependent on staff for bathing, transfers and toileting. Record review of the investigation report dated 10/09/19 revealed Resident #72 ' s family member alleged a concern of finding meds not being sent with the Resident #72 to dialysis for lunch. The facility investigated the family member's grievance and substantiated the allegation. Further review of the investigation report did not reveal the facility followed up with the family in reference to the outcome of the investigation. In an interview with the Social Worker on 11/05/19 at 3:38 PM, she stated she does not do a written summary for grievances. In an interview with the Administrator on 11/05/19 at 3:45 PM, she revealed the grievance reported by Residnet#72's family member was resolved on 10/10/19. She explained no written summary was provided to the family, just a verbal notification annotated on the grievance/concern form. She acknowledged the family should have been provided a written resolution and summary about the outcome of the investigation.	F 585	quarterly), Administrator, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager RN, Unit Coordinator □LPN, Social Services, Activities Director, Dietary Manager, Maintenance Director, Central Supply/ C NA. Pharmacy consultant (usually attends quarterly), Medical Records/C NA, MDS RN and LPN. On 11/7/2019, the Administrator met with the President of the Resident Council to review the grievance process and new changes for the written grievance response letter. The Resident Council President was in agreement with the new grievance response letter. On 11/21/2019, a written resolution was issued and sent via certified mail to the RP of Resident # 72 for the grievance which was submitted on 10/8/2019 and resolved on 10/10/2019. The Administrator conducted a Quality Review of the Grievance Log on 11/20/2019 of grievances submitted 10/1/2019 to 11/20/2019. (76) written grievance response letters were issued by hand delivery or mailed as appropriate by 11/22/2019 to the RP or Resident submitting the grievance. An Ad Hoc QAPI Committee meeting was held on 11/22/2019 with the Divisional Clinical Quality Specialist. The Divisional Clinical Quality Specialist and the Administrator provided re-education to the QAPI Committee on 11/22/2019 regarding the new grievance process to include the written grievance resolution response letter. The Administrator /designee will monitor the Grievance resolution process to	

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F 585	Continued From page 8	F 585	ensure written responses are issued to Residents or RP (hand delivered or mailed as appropriate). Utilizing a Quality Improvement Monitoring tool the Administrator / designee will conduct the Quality monitoring weekly x 4 weeks, then monthly x2, then quarterly or as needed. Findings will be reviewed at the monthly QAPI meeting and monitoring will be adjusted based on the findings. Date of compliance will be 11/30/2019.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide ace wraps as ordered by the physician to treat lower extremity edema. This affected 1 of 1 resident sampled with an order for ace wraps to lower extremities (Resident #72). Findings included: Resident #72 was admitted to the facility on 03/09/17 with diagnoses of end stage renal disease, hypertension, chronic obstructive pulmonary disease, atrial fibrillation, anemia, and	F 684	F 684 Quality of Care An Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 11/7/2019. A root cause analysis was conducted regarding the plan of care for Resident #72 regarding ace wrap application and documentation. Physician orders were reviewed; no new orders obtained. The care plan had previously reflected medication refusals; however, was amended on 11/26/2019 to reflect Resident #72 frequent refusals of	11/30/19

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F 684	Continued From page 9 syncope. Review of the Physician ' s Order dated 3/21/19 revealed an order for ace wrap BLE (bilateral lower extremity) every morning remove every evening for edema. Review of the Care Plan last revised on 8/05/19 documented a Focus area of resident having edema to bilateral extremities. The interventions in place included apply ace wraps to bilateral lower extremities on in the mornings and off at bedtime as ordered. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 10/09/19 identified Resident #72 as cognitively intact and required extensive assistance with bed mobility and dressing. Resident #72 was assessed as total dependent on staff for bathing, transfers and toileting. Resident #72 had lower extremity range of motion impairments on both sides. Review of the Treatment Administration Record (TAR) for 10/2019 and 11/2019 documented the ace wrap not being on in the mornings for 31 days of 36 days reviewed. The TAR documented the ace wrap was not taken off on 8 days of 31 days reviewed. There were no documented refusals on the TAR for the ace wraps. During observations on 11/03/19 at 4:30 PM, there were no ace wraps noted on Resident #72 lower extremities while in her room. During observations on 11/04/19 at 9:00 AM, there were no ace wraps noted on Resident #72 lower extremities while in her room.	F 684	ace wrap application. The Director of Clinical Services/ Assistant Director of Nursing conducted a Quality Review 11/15/2019-11/20/2019 of residents with physician orders for treatments from 9/1/2019-11/20/2019. Follow up to the findings included: Physician / NP/ PA and RP notification. Any new orders were documented and care plans updated accordingly. The Director of Clinical Services/Assistant Director of Nursing provided re-education to the licensed nursing staff on 11/15/2019 regarding following doctor□s orders for treatments, documenting the application of the treatment on the Treatment Administration Record (TAR), and documenting any refusals for the treatment. Documentation of notification of refusals to physician and RP. Re-education also included updating care plan to reflect resident choice of refusals for ordered treatments if indicated. Licensed staff that were unavailable for in-servicing will be re-educated prior to returning to work and all newly hired licensed staff will be educated as part of the orientation process. An Ad Hoc QAPI Committee meeting was conducted with the Divisional Clinical Quality Specialist on 11/22/2019 to discuss system change and Quality Monitoring. The Director of Clinical Services/designee will complete Quality Monitoring using a Quality Improvement Monitoring tool of residents with treatments to ensure treatments are rendered per physician□s orders and proper documentation to reflect	

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F 684	Continued From page 10 During an observation on 11/05/19 at 4:20 PM no ace wrap noted on lower extremities of Resident #72. During an interview with NA #1 on 11/05/19 at 5:45 PM, she stated sometimes Resident #72 allows the ace wraps and sometimes she refuses them. During an interview with Resident #72 on 11/05/19 at 6:00 PM she stated she did not feel well, and she was having pain in her legs because they were swollen. She stated she was getting ready to go to lay down in a little while and did not want them wrapped. She explained she likes them on sometimes and sometimes she does not. She stated she will tell the staff sometimes and sometimes she forgets. She admitted she refuses sometimes to allow the staff to place the ace wraps. During an interview with Nurse #2, on 11/06/19 at 9:00 AM she stated Resident#72 did not have ace wraps on today when her shift started. She confirmed sometimes they are on and it depended on who you are. Resident #72 would only allow some staff to apply them and some she would refuse. She stated she tried to explain she needed the wraps to help with her edema, but the Resident #72 would say, "later maybe". During an interview on 11/06/19 at 6:12 PM the Director of Nursing stated the ace wraps should have been on Resident #72 as ordered. She explained her expectation was the nursing staff must follow physician orders and report/document	F 684	completion or refusal. The monitoring will be 3x a week for 4 weeks, then weekly for 4 weeks, and then monthly for 2 months. Finding will be reviewed and discussed at monthly QAPI meetings and modifications to monitoring as appropriate. Date of compliance is 11/30/2019.	

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F 684	Continued From page 11 refusals of care for all residents. She stated she was not aware the resident was not getting her ace wraps applied. Observations on 11/06/19 at 6:13 PM revealed no ace wraps on Resident #72 lower extremities. During an interview on 11/06/19 at 6:15 PM the Administrator stated the ace wraps should have been applied as ordered and if Resident #72 refuses then the refusals should be documented, and the appropriate family and staff be notified.	F 684		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to schedule a Registered Nurse (RN) eight consecutive hours on 36 of 262 days during the weekends and weekdays of January 12, 2019 through September 30, 2019. Findings included:	F 727	F 727 RN Coverage An Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was conducted on 11/7/2019 to review current scheduling processes for RN coverage and conduct root cause analysis. The root cause	11/30/19

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F 727	Continued From page 12 Review of the daily nursing staffing sheets and payroll based journals from January 12, 2019 to September 30, 2019 revealed the following days during the weekend and week days when there was no RN coverage as working on the following days: January 12, 2019 - Saturday - census - 73; January 13, 2019 - Sunday - census- 73; February 2, 2019 - Saturday - census - 73; February 3, 2019 - Sunday - census - 74; March 2, 2019 - Saturday - census - 74; March 3, 2019 - Sunday - census - 75; March 9, 2019 - Saturday - census - 73; March 10, 2019 - Sunday - census - 73; March 16, 2019 - Saturday - census - 73; March 17, 2019 - Sunday - census - 73; March 23, 2019 - Saturday - census - 73; March 24, 2019 - Sunday - census - 73; March 30, 2019 - Saturday - census - 74; March 31, 2019 - Sunday - census - 74; April 6, 2019 - Saturday - census - 74; April 7, 2019 - Sunday - census - 74; April 21, 2019 - Sunday - census - 76; April 28, 2019 - Sunday - census - 79; May 4, 2019 - Saturday - census - 77; May 11, 2019 - Saturday - census - 78; May 12, 2019 - Sunday - census - 78; June 23, 2019 - Sunday - census - 90; July 5, 2019 - Friday - census - 93; July 6, 2019 - Saturday - census - 90; July 7, 2019 - Sunday - census - 90; July 14, 2019 - Sunday - census - 91; July 18, 2019 - Thursday - census - 92; July 19, 2019 - Friday - census - 92; August 4, 2019 - Sunday - census - 90; August 17, 2019 - Saturday - census - 91; August 25, 2019 - Sunday - census - 92; September 7, 2019 - Saturday - census - 91; September 12, 2019 - Thursday - census - 88; September 13, 2019 - Friday - census - 85; September 15, 2019 - Sunday - census - 82; September 22, 2019 - Sunday - census - 87. During an interview with the Administrator on	F 727	analysis revealed that facility process for updating and monitoring RN staffing hours did not include validation of actual RN hours to include supplemental RN hours. (2) Supplemental temporary RN□s were added to the staffing schedule to comply with 8 consecutive hours in a day on 11/12/2019 to ensure compliance of RN hours (8 consecutive hrs./day) until permanent RN staffing stabilized. The Administrator conducted a Quality Review on 11/20/2019 of the RN hours from 10/1/2019-11/20/2019. The review revealed 51 days of 51 days had 8 consecutive hrs. /day. (2) Supplemental Agency RNs were added to the staffing roster to ensure 8 consecutive hours in a day. The Administrator re-educated the Director of Clinical Services and the Scheduler to have RN coverage 8 consecutive hours in a day and ensure supplemental agency RN hours are added to the staff posting. The RN hours will be posted on the Daily Staff Posting. An Ad Hoc QAPI Committee meeting was conducted with the Divisional Clinical Quality Specialist on 11/22/2019 to discuss and review systemic changes to ensure RN coverage. The Administrator and the Director of Clinical Services will complete Quality Monitoring of RN hours utilizing Quality Improvement Monitoring tools to ensure 8 consecutive RN hours in a day. The Quality monitoring will be done 5x a week (M-F) for 2 weeks and then 2x a week for 2 weeks and then weekly for 4 weeks and then monthly for 2 months. The findings will be reviewed at	

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F 727	Continued From page 13 11/06/19 at 4:00 PM, she stated that she was employed at the facility on 09/03/19 and it is her expectation that RN coverage is in the building 8 consecutive hours in 24-hour period 7 days a week.	F 727	the monthly QAPI meetings and the monitoring will be modified based on the findings. The date of compliance is 11/30/2019.	
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 and staff interviews, the facility failed to lock an unattended medication cart for 1 of 4 medication carts observed (100 hall	F 761	F 761 Medication Storage An Ad Hoc Quality Assurance Performance Improvement Committee	11/30/19

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F 761	Continued From page 14 medication cart). Findings included: During an observation on 11/04/19 at 9:00 AM the 100-hall medication cart was observed to be unlocked with the cart's push in lock observed to be in the out position and the nurse was not in view of the cart. The top right drawer was slightly dislodged. The cart was unattended and positioned on the 100 hallway. The nurse was observed to return to the cart within one minute coming from a resident's room one door down the hall from the location of the cart. There were no residents observed in the hallway near the cart at the time. During an interview on 11/04/19 at 9:05 AM with Nurse #1 she stated she should have made sure the cart was locked before walking away. During an interview with the Director of Nursing on 11/05/19 at 4:59 PM she stated her expectation was to have medication carts secured. During an interview with the Administrator on 11/06/19 at 6:28 PM she stated her expectation was medication carts were always to be secured by staff.	F 761	(QAPI) Committee meeting was conducted on 11/7/2019 to complete a root cause analysis. The Nurse assigned to the medication cart immediately locked the medication cart when the issue was identified. The Director of Nursing and Assistant Director of Nursing conducted a Quality Review on 11/15/2019 to ensure unattended medication carts are locked. All medications (4) and (2) treatment carts were observed to be locked when unattended. The Director of Nursing/ Assistant Director of Nursing re-educated the licensed nursing staff on 11/15/2019 regarding proper medication storage to include locking medication/treatment carts when unattended. Licensed staff that were unavailable for in-servicing will be re-educated prior to returning to work and all newly hired licensed staff will be educated as part of the orientation process. An Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was conducted on 11/22/2019 with the Divisional Clinical Quality Specialist to review systemic changes and Quality Monitoring to ensure proper medication storage/locked medication carts when unattended. The Quality Monitoring will be done by the Director of Nursing /designee utilizing Quality Improvement Monitoring tools 5x a week for 2 weeks, then weekly for 2 weeks and then monthly for 2 months. The findings will be discussed and reviewed at the monthly QAPI Committee	

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F 761	Continued From page 15	F 761	meetings. Date of compliance 11/30/2019.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of 1/11/2019. This was for one deficiency that was originally cited at the regulatory grouping of 483.15 in January of 2019 and subsequently recited on the current recertification survey of 11/6/2019. The repeated deficiency was in the area of Admission, Transfer and Discharge. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This citation is cross referenced to: F623 (483.15) Based on record review and staff interviews, the facility failed to provide written notice of reason for discharge to hospital to resident representative for 1 of 1 resident (Resident # 86) reviewed for hospitalization. The facility was cited during the 1/11/2019 survey	F 867	F867 Q A A An Ad Hoc QAPI Committee meeting was held on 11/7/2019 to review the current process to provide written notification to Responsible Party (RP) of discharge to the hospital. Root cause analysis was conducted and discussed previous QAPI plan for notification of discharge was reviewed and changes necessary for implementing and maintaining an effective Quality Improvement Plan with the QAPI process. On 11/25/2019, a written letter of discharge notification of reason for discharge to the hospital was issued and sent via certified mail to the RP of Resident #86. The Administrator conducted a Quality Review of the Discharge Log on 11/20/2019 of discharges to the hospital between 9/1/2019 to 11/1/2019. There were #17 discharges to the hospital and 0 written discharge notification letters were issued to RPs. On 11/25/2019 17 written letters with reason for discharge were issued (by hand delivery or mailed as	11/30/19

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F 867	Continued From page 16 at 483.15, for failure to provide written notice of reason for discharge to hospital to resident representative. During the current recertification survey, the facility continued to fail to provide written notice of reason for discharge to hospital to resident representative. In an interview on 11/6/2019 at 4:00 PM, the facility Administrator stated the QAA committee met monthly and identified issues and developed and implemented plans of action to correct deficiencies. The Administrator stated the change of staff at the facility had contributed to the failure of following up to making sure the resident's representative received a notification for discharge to hospital from the facility.	F 867	appropriate to the RP or Resident. On 11/8/2019, The Administrator re-educated the Social Worker regarding the process for written notification to the RP to include the reason for transfer to the hospital. An Ad Hoc QAPI Committee meeting was conducted on 11/22/2019 with the Divisional Clinical Quality Specialist to discuss and review systemic changes to the QAPI process for the notification of discharge to hospital process and the Quality Monitoring Process. The Divisional Clinical Quality Specialist/designee will attend monthly QAPI meetings to do a Quality review on processes and ensure effectiveness of the QAPI Committee Program. The Administrator /designee will monitor process for written notification to the RP of discharge to the hospital (hand delivered or mailed as appropriate). Utilizing a Quality Improvement Monitoring tool the Administrator / designee will conduct the Quality monitoring weekly x 4 weeks, then monthly x2, then quarterly or as needed. Findings will be reviewed at the monthly QAPI meeting and monitoring will be adjusted based on the findings. Date of compliance will be 11/30/2019.	