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	345014	A. BUILDING ______ B. WING ______	C 05/28/2021

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ACCORDIUS HEALTH AT GREENSBORO, LLC	**1201 CAROLINA STREET GREENSBORO, NC 27401**

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E 000	Initial Comments An unannounced Recertification and complaint survey was conducted 5-23-21 through 5-28-21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Q3PV11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted 5-23-21 through 5-28-21. 7 of 16 complaint allegations were substantiated. Event ID Q3PV11	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		6/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/21/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family and staff interviews the facility failed to protect the private health information of 2 of 6 residents {Resident #173 and Resident #177) and the facility failed to protect the private financial information of 6 of 7 resident reviewed for privacy. {Resident #14, Resident #171, Resident #173, Resident #174, Resident #176, and Resident #177) Findings included: During an interview with Resident #15 on 05/25/21 at 1:00 pm she revealed that during the month of December 2020 her family member received information from the business office that included the financial and health information for other residents in the facility. Resident #15 indicated this information had nothing to do with her. Resident #15's family member forwarded an email she had received from the facility dated 12/11/2020 at 3:26 pm that was 11 pages long and contained account information for 6 residents. The e-mail identified Resident #173 and Resident #177 were receiving hospice care.	F 583	A certified letter was sent by the Administrator to all affected parties (Residents #173, 177, 14, 176, 171, 174)notifying them of the accidental breach. This letter also explained Accordius Health's commitment to protecting personal information and to open communication if a breach occurs. The letter included recommendation to call the Administrator with any questions or concerns regarding this breach. Resident #15 family member was asked to delete the email. No other residents or family members were listed on this email. A review of emails and/or correspondences from the Business Office in the last 30 days and in the months of November and December were reviewed by the Administrator on 6/1/2021 and no other breach was identified. Root Cause Analysis determined that this was bad judgement on the Business	

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F 583	Continued From page 2 It additionally identified Resident #14, Resident #176, Resident #171, Resident #177, Resident #174 and Resident #173's payer source and patient monthly liability amounts. The email was not protected and/or encrypted to protect the resident information. During an interview with the Business Office Manager (BOM) on 05/27/21 at 9:00 am she indicated the email that was sent to Resident #15's family member on 12/11/20 was a mistake. The BOM indicated she apologized to Resident #15 and her family member. BOM also indicated that she did not notify the other residents or family member about her mistake. During an interview with the Administrator on 05/28/21 at 8:00 am she stated her expectation was all resident's health and financial information should always be protected.	F 583	Office Manager's part. She knew the code of conduct and privacy rules but made an error that day. The Business Office Manager received training by the Administrator regarding Compliance and Ethics, Code of Conduct and Protection of personal information of all residents on 6/1/2021. All other staff members also received this same education by the Assistant Director of Nursing. The education of all staff will be completed by 6/23/2021. For the next 2 months, any correspondence sent to families, residents or outside organizations will be viewed by the Administrator prior to correspondence being sent to ensure there are no privacy concerns. Correspondence will be summarized and presented to the Monthly Quality Assurance Committee by the Administrator. Any issues identified will be addressed by the committee if they arise and the plan will be revised to ensure continued complaince	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code medication usage on the Minimum Data Set (MDS) assessment.	F 641	The inaccurate MDS assessment for Resident #47 was corrected, submitted and accepted by the Regional MDS	6/23/21

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F 641 Continued From page 3

This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #47).

Findings Included:

Resident #47 was admitted to the facility 12/6/16 and diagnoses included diabetes, congestive heart failure and chronic kidney disease.

Review of the physician ' s orders for Resident #47 revealed an order dated 10/29/20 for Trulicity (an injectable medication to help control blood sugar levels) 1.5 milligrams (mg) every week. There were no orders for the resident to receive insulin.

A quarterly minimum data set (MDS) dated 4/22/21 for Resident #47 identified he had received insulin 1 day during the look-back period.

An interview on 5/26/21 at 2:17 pm with the MDS Nurse and the Regional MDS Consultant revealed the quarterly MDS dated 4/22/21 for Resident #47 was not coded correctly. The Regional MDS Consultant stated insulin should not have been coded as being administered 1 day during the look-back period. She explained the resident had received 1 injection of Trulicity which was an anti-diabetic medication, but not insulin. She added the MDS would need to be corrected and resubmitted.

An interview on 5/26/21 at 4:40 pm with the Administrator revealed she expected a residents MDS should be coded accurately to reflect the resident ' s condition.

F 641

Consultant for 4/22/2021.

An audit was completed for MDS's submitted in past 6 months for any resident having injectable medications to help blood sugar levels to ensure no other errors were made. Audit was completed on 6/15/2021 by the Administrator. Four more errors were found, MDS's corrected, submitted and accepted by the Regional MDS Consultant.

Education was provided to the MDS Coordinator regarding insulin injections and other diabetic medications that are not insulin, including precision needed in distinguishing between the two when completing MDS assessments.
Education was provided on 6/15/2021 by the Regional MDS Consultant.

Audit will be completed weekly for 4 weeks for any resident who requires diabetic management with insulin or medication. Any MDS completed will be audited to check for accuracy. Audits will be completed by the Administrator or Director of Nursing and will continue after 4 weeks for 2 more months on a weekly basis. Any errors found will be immediately corrected and MDS resubmitted.

Results of all audits will be summarized and presented by the Director of Nursing at the monthly QAPI Committee Meeting for the next 3 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the

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F 641	Continued From page 4	F 641	Committee as they arise and the plan will be revised to ensure continued compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		6/23/21

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F 656	Continued From page 5 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive person-centered plan of care that included the daily use of an antipsychotic and antianxiety medication. This was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #16). Findings Included: Resident #16 was admitted to the facility 3/4/21 and diagnoses included epilepsy, dementia, congestive heart failure, urinary tract infection and right femur fracture. Review of the physician ' s orders for Resident #16 included an order dated 3/5/21 for Seroquel (an antipsychotic medication) 0.5 milligrams (mg) every day for dementia and an order dated 3/4/21 for Buspar (an anti-anxiety medication) 15 mg twice daily for anxiety. An admission minimum data set (MDS) dated 3/10/21 for Resident #16 identified she had received an antipsychotic and antianxiety medication for 7 days of the look-back period. The MDS identified the resident had verbal behaviors directed towards others and wandering 1 to 3 days of the look-back period and her	F 656	Resident #16 care plan was reviewed by IDT Team and care plan added on 5/26/21 for use of antipsychotic and antianxiety medications. All other resident care plans for those receiving antipsychotic, antidepressant or antianxiety medications were reviewed by the Administrator on 6/15/2021. 2 residents were identified without care plans for use of medication and care plans were updated by the IDT Team on 6/18/21. 1 new resident whose care plan was being developed, also had medication care plan added to current care plan by the IDT team. Root cause determined that the IDT team was not thorough in their review of medications for care planning and this was included in the education to the IDT Team. Education was provided by the Administrator to the IDT team members regarding the need to identify residents who have current orders for use of antipsychotic, antianxiety and antidepressant medications and the need to identify this on each residents care plan. Care Plan audits will be completed	

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F 656	Continued From page 6 cognition was severely impaired. The care area assessment section identified to proceed to care plan for psychotropic drug use. Review of the care plan dated 3/6/21 for Resident #16 identified a care plan for impaired cognitive function related to dementia and a care plan for the use of an antidepressant. There were no care plans for the use of an antipsychotic or antianxiety medication. An interview on 5/26/21 at 2:21 pm with the MDS Nurse and the Regional MDS Consultant revealed Resident #16 should have been care planned for the use of the antipsychotic and antianxiety medications. The Regional MDS Consultant stated these care plans would be developed for the resident. An interview on 5/26/21 at 4:40 pm with the Administrator revealed she expected residents to have individualized plans of care and Resident #16 should have been care planned for the use of her antipsychotic and antianxiety medications.	F 656	weekly for 4 weeks and monthly for the following 2 months by the Director of Nursing. Care plans will be reviewed to ensure antipsychotic, antianxiety and antidepressant medication use is reflected in all resident care plans for the resident's who use these medications. The Director of Nursing is responsible for all audits of care plans. Results of weekly and monthly care plan audits will be summarized and presented by the director of Nursing at the monthly QAPI Committee Meeting for the next 3 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interviews, the facility failed to provide nail care for a resident that was dependent for activities of daily living (ADL) care. This was evident for 1 of 4 residents (Resident #40)	F 677	Resident #40 has his fingernails cleaned, cut and filed on 5/28/2021. Nursing Assistants on Resident #40's assignment for past 2 weeks were counseled regarding fingernail care during showers	6/23/21

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Continued From page 7

reviewed for ADL care.

Resident # 40 was admitted to the facility on 2/18/20 with multiple diagnosis that included hemiplegia/hemiparesis, obstructive sleep apnea, hypertension, chronic obstructive pulmonary disease, lymphedema, obstructive and reflux uropathy, and hypothyroidism.

The quarterly Minimum Data Set (MDS) dated 4/16/20 revealed Resident #40 was cognitively intact and not coded for refusing care. The MDS also revealed Resident #40 needed dependent assistance with one person for bathing.

Resident #40 ' s care plan last revised on 3/14/19 revealed a Resident #40 had trouble with everyday tasks, that included bathing. The interventions included staff to provide extensive assist with bathing, toileting, and dressing.

On 5/23/21 at 1:05 pm an observation was made of Resident #40. Fingernails on bilateral hands approximately 1 inch in length.

On 5/24/21 at 10:54 am an interview was conducted with Resident # 40 and he stated, "he had asked to have his nails cut; however, no one has done it yet". He stated he did not remember who it was he asked but he knew it was one of the Nurses on the cart.

An Interview was conducted on 5/25/21 at 11:45 am with NA # 1 and she stated she had worked with Resident # 40 before. She stated he sometimes refused care, she stated she offered him a shower when it was his shower day, however he refused his showers. She stated, "I have not asked to cut his nails and he has not

F 677

and daily care. Root cause determined that rounds were not being made on a regular basis by Nurses to ensure care was provided in a timely manner, including fingernail care.

All other residents in the facility had their fingernails inspected on 6/17 and 6/18 by a Certified Nursing Assistant. All fingernails were cleaned, cut if needed and filed on one of those two dates for any resident in need by the Certified Nursing Assistant.

Education was provided by the Assistant Director of Nursing to all Certified Nursing Assistants and Nurses instructing them that fingernails need to be checked on every shower day, cleaned, cut and filed when necessary. They also may be done at any time a resident has long or jagged fingernails. Education will be completed by 6/23/21. Initial audit of all resident fingernails on 6/17 and 6/18 included cleaning, cutting and filing any fingernails in need. Audits will continue every 2 weeks for the next 3 months to ensure all resident fingernails are clean, cut and filed appropriately by the Director of Nursing and/or Assistant Director of Nursing. Any resident found with unacceptable fingernails will require education and/or discipline to the primary Certified Nursing Assistants responsible for this assignment and Nurses who have signed off on those residents shower sheets.

Results of every 2 week audits will be summarized and presented by the

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F 677	Continued From page 8 mentioned to me that he wanted his nails cut". On 5/25/21 at 12:15 pm an interview was conducted with NA #2. She stated Resident # 40 asked her to cut his nails one day last week, but she was unable to cut them because she did not have access to clippers on that day. She explained they were locked in central supply. She stated she had clippers today and would cut his nails. During an interview with the Administrator on 5/26/21 at 3:35 pm, the Administrator stated resident often refused care. She stated the staff had access to the central supply room where the clippers are kept, and she was not sure why staff would say they did not have clippers to cut resident's nails. She stated having agency Nurses made it difficult to keep a check on things like fingernails, however she stated, "I have a new Unit Manager to follow up and do rounds to ensure showers and fingernails are being done".	F 677	Director of Nursing at the monthly QAPI Committee Meeting for the next 3 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		6/23/21

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F 686	Continued From page 9 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, nurse practitioner and staff interview the facility failed to provide daily wound care as ordered by the physician for 13 of 20 days. This was evident for 1 of 2 residents reviewed for pressure ulcers (Resident #64). Findings Included: Resident #64 was admitted to the facility 4/28/21 and diagnoses included critical illness myopathy and history of COVID-19. Review of the admission skin assessment dated 4/28/21 for Resident #64 identified a suspected deep tissue injury to both right and left heels. Review of the April 2021 treatment administration record (TAR) for Resident #64 revealed an order dated 4/30/21 to apply betadine and wrap bilateral feet every three days on Mondays, Wednesdays, and Fridays. The TAR was initialed that the treatment was completed on 4/30/21 and the treatment was discontinued on 4/30/21. An admission minimum data set (MDS) dated 5/4/21 for Resident #64 identified his cognition was intact and he was admitted to the facility with 2 unstageable deep tissue injuries. A care plan for Resident #64 dated 5/11/21 revealed he was at risk for pressure ulcers due to decreased mobility and incontinence and he currently had bilateral heel pressure ulcers. Interventions included to administer treatments as ordered and monitor for effectiveness.	F 686	Treatment for Resident #64 was completed on 5/29/21 by Nurse. Wound Nurse Practitioner examined wounds weekly and has continued daily treatments for Resident #64. Assistant Director of Nursing will be assisting Nurses in treatments to make sure they are completed. Nurses who failed to complete treatments were counseled regarding the need to complete treatments as ordered and ask Assistant Director or Director of Nursing for assistance if needed. All residents with wound treatments are being seen weekly by the Wound Nurse Practitioner. 2 other residents were identified as missing some treatments or documentation of treatments and have since had treatments completed. Nurses who did not complete treatments were counseled regarding the need to complete treatments as ordered and ask the Assistant Director of Director of Nursing for assistance if needed. Education was provided by the Assistant Director of Nursing to all Nurses explaining the importance and necessity of completing all treatments per MD order and signing the treatment record each time. The Assistant Director of Nursing will also be assisting Nurses to make sure treatments are completed as ordered. Treatment records will be audited daily for the next 2 weeks and weekly for 2 months	

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F 686	Continued From page 10 Review of the integrated wound Nurse Practitioner (NP) note dated 5/5/21 for Resident #64 revealed the resident was seen for pressure ulcers to both heels. The right foot was identified as unstageable with 100% eschar and measured 18 centimeters (cm) by 4.5 cm. The left foot was identified as unstageable with 100% eschar and measured 18.4 cm by 4.5 cm. Treatment recommendations were to paint with betadine and wrap with kerlix daily. Review of the integrated wound NP note dated 5/12/21 for Resident #64 revealed the resident was seen for pressure ulcers to both heels. The right foot was identified as unstageable with 100% eschar and measured 17.5 cm by 4.5 cm. The left foot was identified as unstageable with 100% eschar and measured 18 cm by 4 cm. Treatment recommendations continued to paint with betadine and wrap with kerlix daily. Review of the integrated wound NP note dated 5/19/21 for Resident #64 revealed the resident was seen for pressure ulcers to both heals. The right foot was identified as unstageable with 100% eschar and measured 17.5 cm by 4.5 cm. The left foot was identified as unstageable with 100% eschar and measured 18 cm by 4 cm. The treatment recommendations continued to paint with betadine and wrap with kerlix daily. Review of the May 2021 TAR for Resident #64 identified an order dated 5/5/21 to apply betadine and wrap feet every dayshift. There was no documentation that the treatment was completed on 5/5/21, 5/6/21, 5/7/21, 5/10/21, 5/11/21, 5/12,21, 5/13/21, 5/15/21, 5/16/21, 5/17/21, 5/18/21, 5/22/21 and 5/24/21.	F 686	to ensure all treatments are completed as ordered. Any blank in the TAR will result in further education and/or discipline for Nurse not completing treatment or documentation for treatment. Audits will be completed by the Assistant Director of Nursing. Results of all treatment audits will be summarized and presented by the Assistant Director of Nursing at the monthly QAPI Committee Meeting for the next 3 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.	

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	345014	A. BUILDING ______ B. WING ______	C 05/28/2021

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F 686	Continued From page 11 An interview on 5/25/21 at 12:12 pm with Resident #64 revealed he was not receiving treatments to his feet daily. The resident stated he believed they did the treatment every 2nd or 3rd day. Resident #64 added he did not know the treatment was supposed to be done daily. An interview on 5/25/21 at 2:03 pm with Nurse #1 revealed she worked with Resident #64 routinely on day shift. She stated the resident had callous like areas on the outer edges of both feet. She added the areas were supposed to be treated with betadine and wrapped daily. The May 2021 TAR was reviewed with Nurse #1 for the days she was assigned to Resident #64 and the treatment was not signed off as being completed. She explained some of the dates that were blank may have been because the resident refused the treatment, but not all the dates. Nurse #1 added if the resident had refused the treatments, she would have reflected this on the TAR. She indicated she did not know why so many days were blank on the TAR and could not confirm if the treatment was done on those days or not. An interview on 5/26/21 at 9:22 am with Nurse #2 revealed she was the nurse for Resident #64 routinely on day shift. She stated she had not completed any treatments to the wounds on his feet. Nurse #2 added sometimes she did not have time to complete the treatments and the Assistant Director of Nursing (ADON) completed the treatments for her. An interview on 5/26/21 at 11:02 am with the integrated wound care NP revealed she assessed Resident #64 ' s wounds weekly and she believed she had been seeing the resident for about 3	F 686		

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F 686	Continued From page 12 weeks. The NP explained she would recommend the wound treatments and it was up to the facility to see that the treatments were completed. She added the resident was supposed to have both feet soaked with betadine and wrapped daily. The NP explained both wounds were 100% necrotic and the betadine would help protect the tissue and lift it up. She stated she would expect the facility to complete the residents wound treatments daily as ordered. An observation on 5/26/21 at 11:08 am of Resident #64 ' s feet revealed there was 100% necrotic tissue the full length (from right below his toes down to and including his heels) on the posterior sides of both feet. An interview on 5/26/21 at 4:40 pm with the Administrator revealed she expected the residents wound care to be performed daily according the physician ' s orders.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		6/23/21

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F 758	Continued From page 13 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and physician interview the facility failed to obtain documentation for the rationale and duration to extend an as needed (prn) order for a psychotropic medication beyond 14 days. This	F 758	Antianxiety medication for Resident #64 was reviewed by Nurse Practitioner and order was discontinued. Another order was given for daily anxiety medication, not PRN. The Nurse responsible for putting	

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F 758 Continued From page 14

was evident for 1 of 5 residents reviewed for unnecessary medications (Resident #64).

Findings Included:

Resident #64 was admitted to the facility 4/28/21 and diagnoses included critical illness myopathy, history of COVID-19 and anxiety disorder.

Review of the admission orders for Resident #64 revealed an order dated 4/28/21 for Diazepam (an anti-anxiety medication) 5 milligrams (mg) half a tablet every 12 hours as needed for anxiety. The resident additionally had an order dated 4/28/21 for Clonazepam (an anti-anxiety medication) 1 mg every evening for anxiety.

Review of the admission physicians progress note for Resident #64 dated 5/4/21 revealed to continue medications as ordered. There was no documentation related to a rationale for the as needed Diazepam order.

An admission minimum data set (MDS) dated 5/4/21 for Resident #64 identified his cognition was intact and he had received anti-anxiety medication for 6 days of the look-back period. There were no mood or behaviors identified on the MDS.

A care plan dated 5/11/21 for Resident #64 identified the resident used psychotropic medications for anxiety and depression. Interventions included to administer psychotropic medications as ordered by the physician.

Review of the medication administration records (MAR) for Resident #64 revealed he had received the Diazepam 5 mg half a tablet on 5/5/21, 5/6/21

F 758

in the PRN order without a 14 day stop is no longer employed. Root cause was determined to be the previous Director of Nursing knew the policy on PRN orders but did not follow the policy. The Medical Director was educated about this order and need for 14 day stop and assessment of need. He, in turn educated both Nurse Practitioners that practice at facility regarding PRN orders.

All other resident records were audited for PRN use of antipsychotic or antianxiety medications and no other issues were found. Only one other resident had a PRN order with a 14 day stop order included and this resident was discharged prior to the 14th day.

Education was provided by the Assistant Director of Nursing to all Nurses explaining the importance and necessity of a 14 day stop order with any PRN antipsychotic or antianxiety medication. Need for medication must be evaluated before 14 days for any continued use. Audits will be completed by the Assistant Director of Nursing weekly for 4 weeks and every 2 weeks for 2 more months to ensure orders are recorded correctly and antipsychotic/antianxiety medications are evaluated appropriately with MD.

Results of all audits will be summarized and presented by the Assistant Director of Nursing at the Monthly QAPI Committee Meeting for the next 3 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the

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F 758	Continued From page 15 and 5/7/21. Review of the medical record for Resident #64 revealed the resident ' s medication regimen review had not been completed by the pharmacist as of 5/25/21. An interview with Resident #64 on 5/25/21 at 12:09 pm revealed he had started on an antidepressant and antianxiety medications during his prolonged hospitalization with COVID-19. Resident #64 stated he felt like these medications had helped him deal with everything he had been through. He explained he took one anti-anxiety medication every night and believed he had requested an extra anti-anxiety medication a few times when he was having a bad day. Resident #64 stated overall he felt like the regular dose he took at night kept him calm. An interview on 5/26/21 at 4:40 pm with the Administrator revealed the facility should not have any as needed orders for psychotropic medications, but if deemed necessary by the physician they should only be ordered for 14 days and include a stop date. A phone interview on 5/27/21 at 12:33 pm with the Physician for Resident #64 revealed because the resident was not over 65 years old his risk for complications from the anti-anxiety medications was lessened. He explained due to his age his body was better able to metabolize the medication than someone over 65. The Physician stated he did recognize from a regulatory standpoint psychoactive medication were only supposed to be ordered for 14 days or less and the order for the as needed Diazepam should have had a stop date. He added he would	F 758	Committee as they arise and the plan will be revised to ensure continued compliance.	

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F 758	Continued From page 16 re-evaluate the need for the resident to have the as needed Diazepam and if he felt it was needed by the resident, he would add a stop date to the order.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to discard 21 containers of thickened cranberry drink that had expired. This was evident in 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 5/23/21 with Cook #1 revealed 10 - 46-ounce containers of thickened cranberry drink with an expiration date	F 812	No residents were affected by the stored, outdated honey thickened cranberry juice as it was in the emergency supply and was sealed, had not been used. This juice was discarded and new supply was ordered to replace it in emergency supply. Root cause determined the Dietary Director was not routinely checking behind the aides for outdated supplies as she usually did.	6/23/21

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F 812	Continued From page 17 of 10/16/20 and 11 - 46-ounce containers of thickened cranberry drink with an expiration date of 4/22/21. An interview with Cook #1 revealed these items should have been discarded by the use by date and would be discarded. An interview on 5/25/21 at 11:40 am with the Dietary Manager revealed the containers of thickened cranberry drink should have been used or discarded by the use by date. She stated she believed these had been overlooked when she checked the dry storage room for expired products. An interview on 5/26/21 at 4:40 pm with the Administrator revealed she expected foods to be monitored for expiration dates and discarded accordingly.	F 812	Any residents who have orders for honey thickened liquids had the potential to be affected. There was only one resident on honey thickened liquids in the facility and she did not receive this juice as it was reserved in the emergency supplies and this resident has also been discharged. Education was provided by the Administrator to all Dietary Staff members to check expiration dates and rotate stock regularly to ensure expired products are not stored in the kitchen. Audit by Dietary Manager of all other products in kitchen found no other expired products on 5/28/2021. Audits will continue weekly for 2 months to ensure all expired products are removed by the expiration date, including the emergency supplies. Results of all audits will be summarized and presented by the Dietary Manager at the monthly QAPI Committee Meeting for the next 2 months to ensure compliance is achieved. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.	