STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKESBORO HEALTH AND REHABILITATION	**204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted 11/29/21 through 12/02/21. The facility was found in compliance with the requirement CFR 487.73, Emergency Preparedness. Event ID #213W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted 11/29/21 through 12/02/21. Event ID #213W11. There were a total of 17 complaint allegations investigated and 2 were substantiated.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		1/10/22

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

Electronically Signed | 12/22/2021

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 657	Continued From page 1 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise a resident's care plan for weight loss for 1 of 7 residents (Resident #14) reviewed for nutrition. The finding included: Resident #14 was admitted to the facility on 02/08/17 with diagnoses of end stage renal disease and hemodialysis. The quarterly Minimum Data Set (MDS) assessment dated 10/03/21 revealed Resident #14 had severe cognitive impairment and required supervision of one person for eating. The MDS also indicated Resident #14 had a diagnosis of malnutrition and had a 5% or more weight loss in the last month or 10% or more in the last 6 months and was not on a physician's prescribed weight loss regimen. Resident #14 did not have a feeding tube at the time of the 10/03/21 MDS. A review of Resident #14's medical record revealed a feeding tube placed on 10/27/21. A review of Resident #14's Physician orders revealed the following active orders: 1. (Brand name) tube feeding formula three times a day via feeding tube at 5:00 AM, 2:00 PM and 8:00 PM for weight loss. This order was started on 10/28/21.	F 657	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. An alleged deficiencies cited have been or will be completed by the dates indicated. The need for gastrostomy feeding was added to the care plan of resident #14 on 12/2/2021 by the MDS Coordinator. 100% audit of care plans for all residents requiring gastrostomy feedings was completed on 12/5/2021 to ensure accuracy by the MDS Coordinator. No corrections were needed as the result of this audit. The MDS Coordinators were in-serviced by the Regional Reimbursement Manager regarding accuracy of care plans on 12/22/2021. The Regional Reimbursement Manager will audit 10% of the facility care plans for residents that require gastrostomy feeding to ensure accuracy weekly for four weeks,	

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F 657	Continued From page 2 2. Regular puree diet by mouth of fortified food at all meals. This order was started on 11/3/21. On 12/02/21 a review of Resident #14's current care plan for weight loss revealed there was no feeding tube documented as an intervention to Resident #14's weight loss care plan. During an interview on 12/02/21 at 11:28 AM the Minimum Data Set (MDS) Nurse acknowledged there was no care plan for Resident #14's feeding tube. The MDS Nurse explained she updated the care plans quarterly and as needed when there was a new intervention put into place such as an intervention after a fall. The MDS Nurse continued to explain that Resident #14's feeding tube was a new intervention for her weight loss and that she should have updated the care plan to include the feeding tube. The MDS Nurse stated she should have remembered to update the care plan because she had been aware of Resident #14's feeding tube placement for several months. During an interview with the Administrator on 12/02/21 at 11:44 AM she stated she reviewed Resident #14's weight loss care plan for the addition of the feeding tube intervention. The Administrator acknowledged the feeding tube was not present on the care plan and explained the care plans were updated quarterly and as needed and the feeding tube intervention should have been added to the weight loss care plan by now.	F 657	then 5% weekly for four weeks, then 5% monthly for one month. The Administrator will report the findings of these audit to the facilities Quality Assurance Committee monthly for three months and thereafter as directed by the committee,	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		1/10/22

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F 686	Continued From page 3 §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 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Doctor interview the facility failed to identify and assess a change in a resident skin condition for 1 of 3 residents reviewed for pressure ulcers (Resident #143) resulting in the development of an unstageable deep tissue injury to the residents sacral area. The findings included: Resident #143 was admitted to the facility on 09/13/21 with diagnoses that included: surgical after care of right femoral neck fracture, peripheral vascular disease, chronic kidney disease stage 3, vascular dementia, and others. Review of the 5-day admission Minimum Data Set (MDS) dated 09/19/21 indicated that Resident #143 was severely cognitively impaired for daily decision making and required extensive assistance with bed mobility and transfers. The MDS further indicated Resident #143 was at risk for developing pressure ulcers but had none on admission. The MDS did indicate Resident #143	F 686	Unable to correct for resident#143. He is no longer a resident at the facility. Skin audits were completed for all inhouse residents on 12/22/2021 by the Director of Nursing, Assistant Director of Nursing and Unit Managers. Any identified area were reported to the physician, responsible party and treatment orders obtained. All Nursing staff was in-serviced on 12/16/2021 by the Assistant Director of Nursing regarding procedures if a new skin integrity issue is noted. Nursing Staff will not be allowed to work until they have completed this in-service. The in-service will be added to the Nursing Orientation for new employees. The Director of Nursing, Assistant Director of Nursing or Unit Managers will verify the accuracy of 10% of the weekly skin assessments completed weekly for four weeks and the 5% for eight weeks. The Director of Nursing will present these audits to the facility Quality Assurance Committee monthly for three months and	

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F 686	Continued From page 4 had a surgical wound on admission to the facility. Review of a Wound Assessment dated 09/13/21 indicated Resident #143 had a surgical incision to his right hip. The wound Assessment was completed by Nurse #2. Review of Skin Assessment dated 09/20/21 indicated Resident #143 had no skin impairment. The assessment was completed by Nurse #2. Review of a Wound Assessment dated 09/23/21 indicated that Resident #143's surgical incision was healed. The Wound Assessment was completed by Nurse #2. A Nurse Practitioner (NP) note dated 09/24/21 read in part, discussed that patient will most likely need long term skilled nursing care due to comorbidities and baseline prior surgery. Palliative or Hospice care would also be appropriate at this time given poor overall prognosis. Family voice understanding. The note was electronically signed by the NP. Review of a nurses note dated 09/26/21 at 1:57 PM read in part, Resident was observed to have moderate amount of rectal bleeding. Vital signs taken and heart rate shown to be between 180-190 and blood pressure 108/54. Resident was very lethargic. The on-call provider notified and requested resident to be sent to the Emergency Room (ER) for evaluation. Report called to the local hospital. The note was signed by Nurse #2. Review of an Emergency Department (ED) to hospital admission dated 09/26/21 read in part, deep tissue pressure (injury to the deep layers of	F 686	thereafter as directed by the committee.	

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F 686	Continued From page 5	F 686		

skin) injury to buttock, deep purple tissue injury around the coccyx and pink blanchable (when pressed on the skin the blood leaves the capillaries leaving the skin pale) stage 1 around the outside of the deep tissue injury that was present on admission to the ER. The admission was electronically signed by Medical Doctor (MD) #1.

Review of a Wound Care Consult note from the local hospital dated 09/28/21 read in part, noted to have a deep tissue injury to coccyx area and rectum noted to be necrotic. Area cleaned with soap and water and dressing applied. The note was electronically singed by the Wound Care Nurse from the local hospital.

Review of a hospitalist discharge summary dated 09/29/21 read in part, principal discharge diagnoses hematochezia (blood coming from rectum) complicating deep pressure wound of the rectum in the setting of end stage dementia and recent hip fracture.

Nurse #2 was interviewed via phone on 11/29/21 at 4:34 PM. Nurse #2 explained that she was the former wound nurse at the skilled facility and was only in that position for approximately 3 months. Nurse #2 stated that she recalled Resident #143 but could not recall any other wounds he had except for his surgical incision. She added that she would check on Resident #143 daily because of his surgical incision and because he was on a blood thinner, but her daily check only included assessing his surgical incision. Nurse #2 explained that on 09/26/21 she was the nurse on call and had received a call stating that Resident #143 had some rectal bleeding, so she came to the facility to assess the situation. Nurse #2

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F 686	Continued From page 6	F 686		

stated that Medication Aide (MA) #2 had reported the rectal bleeding to Nurse #1 in addition to Nurse #2. Nurse #2 stated when she arrived at the facility, she assessed Resident #143 and he was noted to have bright red blood coming from his rectum, she further explained she did not see any signs of deep tissue injury or skin breakdown that she could recall. Resident #143's pulse was 150 and he did not look well so the on-call provider was called, and Resident #143 was sent to the ER.

MA #2 was interviewed on 11/30/21 at 10:28 AM. MA #2 stated that on 09/26/21 she was caring for Resident #143 and around 8:00 AM to 8:30 AM she and Nurse Aide (NA) #1 went into provide incontinent care to Resident #143 and when we rolled him over, he was noted to have dark red blood in his brief and his "anus was black." She stated that they continued to provide care to Resident #143 and once they were finished, she had gone to Nurse #1 to report the bleeding and the condition of his anus. MA #2 stated that Nurse #1 came to Resident #143's room and looked at the brief and when offered to stand Resident #143 up so she could assess the wound Nurse #1 decline and exited room without looking at Resident #143's bottom. She added that the black part was not a bruise and initially she thought it was feces until she tried wiping it off and it would not come off, she explained the "black area was right around the anus." MA #2 also stated that "at the top of his coccyx he had a healing bed sore, that was healing it was red but not open." When Nurse #2 came to the facility on 09/26/21, MA #2 stated she did look at Resident #143's bottom and eventually Nurse #2 sent Resident #143 to the ER.

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F 686	Continued From page 7	F 686		

Nurse #1 was interviewed on 11/30/21 at 10:20 AM. Nurse #1 stated she did not recall Resident #143 and after reviewing his medical record recalled that he had some bleeding from the rectum. Nurse #1 did not recall if MA #2 had reported anything about Resident #143 coccyx area but stated she did recall looking at Resident #143's brief on 09/26/21 and it "had right much blood in it."

Multiple attempts were made to speak to NA #1 on 11/30/21 and 12/01/21 without success.

The local hospital Wound Care Nurse was interviewed via phone on 12/01/21 at 10:46 AM. The Wound Care Nurse stated she evaluated Resident #143 on 09/28/21 in the hospital and he had an unstageable pressure ulcer to both his sacrum and rectal area. She explained the one on Resident#143's coccyx was deep purple and non-blanchable and explained it would have taken "quite some time for the wounds to get that advanced." She added that Resident #143's rectum was necrotic as well. The wounds were documented by the admitting ER nurse on 09/26/21 at 6:42 PM approximately 4 hours after he arrived in the ER and a consult was placed for her to see and assess the wounds which she did on 09/28/21.

MD #1 was interviewed via phone on 12/01/21 at 1:41 PM. MD #1 stated that he examined Resident #143 when he was being admitted from the ER to acute care on 09/26/21. Resident #143 was noted to have an unstageable deep tissue wound to his coccyx and sacral area. MD #1 stated he could not recall what they looked like but stated Resident #143 was very weak and deconditioned. He added that although Resident

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F 686	Continued From page 8 #143's wound may have been unavoidable they would have taken several days to weeks to develop to the point they were when he came to the ER on 09/26/21. The Director of Nursing (DON) was interviewed on 12/02/21 at 12:49 PM. The DON stated that Resident #143 was very demented and had a left hip fracture that had been repaired. Sometime on the 09/26/21 Resident #143 had some rectal bleeding and the nurse on call came to assess him and ended up sending him to the ER. The DON stated she would have expected Nurse #1 to assess the wound and make a judgement call on how to proceed. The NP was interviewed on 12/02/21 at 1:42 PM. The NP stated that while Resident #143 was initially in the hospital he had a somewhat complicated course that ultimately required a blood transfusion. Despite working with therapy when he came to the nursing facility, Resident #143 was really just not making great improvements. The NP added that while Resident #143 was in the facility he had closely monitored his hemoglobin level and it had gone up. He further explained that he did not recall Resident #143 having any wound but added he would not be surprised if he had signs of skin breakdown because he was not eating and was very skinny.	F 686		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		1/10/22

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F 732	Continued From page 9 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interview the facility failed to accurately post the resident census for 3 of 4 days reviewed for nurse posted staffing information. The findings include:	F 732	The daily nursing staff posting in the front lobby was corrected on 12/2/2021 by the Assistant Director of Nursing. There is only one area in which the daily staffing is posted. The Nursing Scheduler and Administrative	

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F 732	Continued From page 10 Observations of the Nurse Posted Staffing sheets located at the front entrance were as follows: *11/29/21 at 3:37 PM the daily resident census was 102 *11/30/21 at 8:46 AM the daily resident census was 100 *12/01/21 at 8:43 AM the daily resident census was 102 An interview was conducted with the Director of Nursing (DON) on 12/01/21 at 5:05 PM. The DON explained that the daily resident census documented on the nurse posted staffing information sheet at the entrance of the facility included all the residents in the facility which were the skilled residents as well as the residents who resided in the assisted living beds. The DON explained that she was never taught that the daily resident census should only include the skilled residents in the facility and should not have included the residents who resided in the assisted living beds therefore, she had been including all the residents of the facility in the daily resident census since she became the Director of Nursing which was about 18 months prior. During an interview with the Administrator on 12/02/21 at 9:07 AM she explained that she only looked at the dates on the nurse posted staffing information sheets to ensure that the information was posted every day and did not pay attention to the actual number of daily resident census indicated on the sheets. The Administrator stated the DON had been educated that the assisted living beds were not included in the total resident census and that only the skilled residents were included on the nurse posted staffing information.	F 732	Nurses were in-serviced on 12/2/2021 by the Administrator that only nursing home residents and staff are included in the daily staff posting. The Administrator will audit the daily staffing post daily for two weeks, then twice a week for ten weeks for accuracy. The Administrator will report findings of these audits to the facility Quality Assurance Committee monthly for three months and thereafter as directed by the committee.	

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner, and staff interview the facility failed to maintain a medication error rate of 5% or less as evidence by 2 medication errors out of 27 opportunities which resulted in a 7.41% medication error rate. This affected 2 out of 8 residents observed during medication pass (Resident #66 and Resident #74). The findings included: 1. Resident #66 was admitted to the facility on 04/08/21 with diagnoses that included disorder of the thyroid and congenital hypothyroidism. Review of a physician order dated 04/13/21 read, Levothyroxine (used to treat disorders of the thyroid) 75 micrograms (mcg) by mouth every day. Review of a physician order dated 05/18/21 read, change Levothyroxine to 88 mcg by mouth every day. An observation of Medication Aide (MA) #1 was made on 11/30/21 at 4:31 PM. MA #1 was preparing Resident #66's medication. She was observed to dispense Levothyroxine 75 mcg into a medication cup along with Resident #66's other medication. Once the medications were in the	F 759	The correct dose of Synthroid was ordered from the pharmacy on 12/2/2021 by the Director of Nursing and was delivered from the pharmacy on 12/2/2021.The correct dose of Vitamin D was purchased on 12/2/2021 by the Central Supply Clerk and was delivered to the facility on 12/2/2021. The physician and respective responsible parties were notified of the medication error on 12/2/2021 by the Unit Manager. An audit of physician orders to compare medications in the medication cart and in the medication storage room was completed for 100% of inhouse residents on 12/16/2021 by the Director of Nursing, Assistant Director of Nursing and Unit Managers. All licensed nurses and medication aides were in-serviced on the 6 rights of medication pass on 12/16/2021. Licensed nurses and medication aides, including agency staff will not be allowed to work until they have completed this in-service. The in-service will be added to the licensed nurse and medication aide and agency orientation for new employees. The Director of Nursing, Assistant Director of Nursing and Unit Managers will complete an audit of physician orders to	1/10/22

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	345401	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 759	Continued From page 12 medication cup MA #1 entered Resident #66's room and administered the medication. An interview was conducted with MA #1 on 12/02/21 at 3:19 PM. MA #1 stated that during the observed medication pass she did verify the medications she gave but was so nervous she did not notice the dose was incorrect. MA #1 stated that the card of Levothyroxine 75 mcg must have been in the medication room and pulled and placed by accident on the medication cart. An interview with the Director of Nursing (DON) was conducted on 12/02/21 at 12:41 PM. The DON explained that when Resident #66 admitted to the facility she was on the rehab unit of the facility and then she had an extended hospital stay and returned to the facility. When she returned her medications were again ordered from the pharmacy and the extra medications were stored in the medication room. Shortly after Resident #66 returned from the hospital her Levothyroxine dosage was changed; it was ordered from the pharmacy and the Levothyroxine 75 mcg was removed from the medication cart, but the staff failed to remove the extra cards of medication located in the medication room. When the staff ran out of medication that was located on the medication cart, they went to the medication room, and accidently pulled the Levothyroxine 75 mcg instead of the 88 mcg as ordered. The DON stated that they had to educate the staff that when a medication was discontinued or changed that they had to remove not only the medication located on the medication cart but what was kept in the medication room as well. The DON explained that the facility had just completed an audit of the medication orders to the medication	F 759	compare medications in the medication cart and in the medication storage room for 10% of the residents weekly times four weeks, then 5% weekly for eight weeks. The Director of Nursing will report the findings of these audits to the facility Quality Assurance Committee monthly for three months and thereafter as directed by the committee.	

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F 759	Continued From page 13	F 759		

carts last week and everything was correct at that time.

An interview was conducted with the Nurse Practitioner (NP) on 12/02/21 at 1:42 PM. The NP stated that he recalled changing Resident #66's dose of Levothyroxine because her labs were off, and she had some tremors. The NP stated that he tried to keep Resident #66's Thyroid Stimulating Hormone (TSH) level between 7-10 and when he checked Resident #66's TSH was 12 so he had adjusted her dose to the 88 mcg. The NP further explained that no medical harm came from Resident #66 receiving the incorrect dose of Levothyroxine but added he expected the staff to administer medications as ordered.

2. Resident #74 was admitted to the facility on 01/06/20 with diagnoses that included vitamin D deficiency.

Review of a physician order dated 05/08/20 read, Vitamin D3 125 micrograms (mcg) (5000 units) by mouth every day for vitamin D deficiency.

An observation of Medication Aide (MA) #2 was made on 12/01/21 at 9:29 AM. MA #2 was preparing Resident #74's medications which included Vitamin D 25 mcg (1000) units. Once MA #2 had prepared all of Resident #74's medication she entered Resident #74's room and administered the medications.

An interview was conducted with MA #2 on 12/02/21 11:53 AM. MA #2 stated that the Vitamin D 25 mcg (1000 units) was the only Vitamin D on the medication cart and available for her to administer. She stated she thought that was the correct thing to administer to Resident #74 and

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F 759	Continued From page 14 did not realize there was a difference in the dosages. An interview was conducted with the Director of Nursing (DON) on 12/02/21 at 12:41 PM. The DON stated that the pharmacy did not supply the Vitamin D medication and they had to order those from another supply company. The DON stated that the order should have changed to administer 5 of the 1000-unit tablets or if had she been aware, she would have ordered the 5000-unit tablets. The DON stated she did not realize that the facility did not have the correct dose of the Vitamin D or she would have ordered or obtained the correct dose. An interview was conducted with the Nurse Practitioner (NP) on 12/02/21 at 1:42 PM. The NP stated hat he had checked Resident #74's Vitamin D level recently and it was on the low end of normal and he did not adjust the dosage at that time. The NP stated that Resident #74 had no ill effects from the incorrect dose of Vitamin D but stated he expected the staff to administer the medications as ordered.	F 759		
F 761 SS=E	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	F 761		1/10/22

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F 761	Continued From page 15 §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 remove loose unsecure medications from the medication cart drawers for 3 of 3 medication carts reviewed for medication storage (300 Hall Cart, 200 Hall Cart #3 and #2). The findings include: An observation was made on 12/02/21 at 12:18 PM of the 300 Hall medication cart. The observation revealed 8 unidentified medications of various shapes, sizes and colors and a half of a white tablet lying loose and unsecure in the drawers of the medication cart. An interview was conducted with Medication Aide (MA) #2 on 12/02/21 at 12:18 PM. The MA who had been employed for 2 years observed the loose medications and stated she could not identify the various medications and that the medications should not be loose in the drawers. The MA explained that the medication carts	F 761	The lose pills found during the medication cart observation were destroyed immediately on 12/2/2021 by the Unit Manager. All medication carts were audited for proper storage of medication and cleanliness on 12/16/2021 by the Director of Nursing, Assistant Director of Nursing and Unit Managers. Any negative findings were corrected at the time of the audit by the Director of Nursing, Assistant Director of Nursing and Unit Managers. All licensed nurses and medication aides ere in-serviced by the Assistant Director of Nursing on 12/16/2021 regarding proper medication storage and medication cart cleanliness. Licensed nurse and medication aides will not be allowed to work until they have completed the in-service. The in-service will be added to the licensed nurse and medication aides orientation for new employees.	

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F 761	Continued From page 16 should be cleaned daily. An observation was made of the 200 Hall medication cart #3 and medication cart #2 on 12/02/21 at 12:38 PM. The observations revealed 5 unidentified medications of various shapes, sizes and colors and 2 white medication pieces lying loose and unsecure in the drawers of the #3 medication cart. An observation of the #2 medication cart yielded one white capsule lying loose and unsecure in the drawer of the medication cart. An interview was conducted with Medication Aide #3 on 12/02/21 at 12:38 PM. The MA who had been employed for 9 days stated she could not identify the loose medications and that the medications should not be loose in the medication cart. The MA explained she thought the medication carts should be cleaned daily. Interviews were conducted with the Unit Manager (UM) #1 and the Administrator on 12/02/21 at 1:04 PM. The UM explained that all the medication carts were thoroughly checked and cleaned on Monday (11/29/21) and indicated the amount of loose medications should not have been found in the medication carts. The UM stated the nurses should be keeping the medication carts clean every day. The Administrator added, the loose medications should not have been found in the medication carts.	F 761	The Director of Nursing, Assistant Director of Nursing and Unit Managers will audit 50% of the medication carts for proper storage of medications and cleanliness twice a week for four weeks, then weekly for eight weeks. The Director of Nursing will report the findings of these audits to the facility Quality Assurance Committee monthly for three months and thereafter as directed by the committee.	
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 -	F 812		1/10/22

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F 812	Continued From page 17 §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 observation and staff interviews, the facility failed to discard expired food in 1 of 1 walk in refrigerator and failed to remove open and expired milk in 1 of 4 facility dining room refrigerators. Findings include: An initial tour of the kitchen on 11/29/21 at 10:10 AM with the Dietary Supervisor revealed a 1 gallon container of extra heavy mayonnaise opened with no date when opened and a bag of shredded lettuce with a use by date of 11/10/21. Observations of the facility's dining room refrigerators on 12/01/21 at 9:10 AM revealed an open carton of white milk dated 11/30/21 and 2 unopened cartons of white milk dated 11/30/21. An interview with the Dietary Supervisor on	F 812	The gallon container of heavy mayonnaise and the bag of shredded lettuce were discarded on 11/30/2021 by the Dietary Manager. The expired milk was discarded on 12/1/2021 by the Dietary Manager. All refrigerators in the facility (kitchen walk-in, kitchen reach-in, kitchen 2 compartment, nourishment room, ADL suite, activity room, main dining room, 400 hall dining room, and nursing station) were inspected by the Dietary Manager on 12/14/2021. Any outdated or improperly labeled food was discarded during this audit by the Dietary Manager. The dietary staff was in-serviced on proper food storage and labeling on 12/16/2021 by the Dietary Manager. Dietary staff will not be allowed to work until they have completed this in-service.	

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F 812	Continued From page 18 11/29/21 at 10:10 AM revealed the Kitchen Manager checked the dates twice a week in the dry storage area, and the walk in refrigerator and freezer. The Dietary Supervisor further revealed the kitchen had a runner that checked the facility hallway refrigerators in the mornings and in the afternoons by 3:00 PM. The Dietary Supervisor stated the lettuce and mayonnaise should have been thrown out and further stated she would have liked for them to date food when it was opened. The Dietary Supervisor indicated they would all need to get together to discuss the food items that were found. During an interview on 12/02/21 at 12:30 PM the Administrator revealed she was aware of the issues in the kitchen and facility hallway refrigerator. She further revealed she expected food to be dated when opened and discarded after the expiration date.	F 812	The in-service will be added to the dietary staff orientation for new employees. The Dietary Manager or Kitchen Supervisor will audit 50% of the facility refrigerators three times a week for four weeks and then weekly for eight weeks. The Dietary Manager will report findings of these audits to the facility Quality Assurance Committee monthly for three months and thereafter as directed by the committee.	