STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 04/21/2023

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LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/17/23 through 04/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 606T11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 04/17/23 through 04/21/23. Event ID# 606T11. The following intakes were investigated: NC00200795, NC00200759, NC00200346, NC00198722, NC00197901, NC00196152, and NC00196089. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G. 4 of the 20 complaint allegations resulted in deficiency.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 25 residents reviewed for resident assessments (Resident #16). Findings included:	F 638	F638 Quarterly Assessment at Least Every 3 Months Corrective Action Minimum Data Set assessment for affected resident that were identified as not being completed within the required timeframe was completed and submitted	6/6/23

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

Electronically Signed | 05/18/2023

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F 638	Continued From page 1 Resident #16 was admitted to the facility on 2/25/19. Record review revealed Resident #63's most recently completed Minimum Data Set (MDS) assessment was dated 12/29/22. There were no further completed MDS assessments. During an interview on 4/19/23 at 1:39 PM the Corporate MDS Consultant stated Resident #16's quarterly minimum data set assessments was not completed by the required time frame. She reported the facility did not have a full-time MDS Coordinator but does have someone filling in on a part-time basis. During an interview on 4/20/23 at 9:35 AM the Administrator stated Minimum Data Set assessments should be completed timely. He reported the facility is currently working to secure a full-time MDS Coordinator.	F 638	to the state database as follows: • Resident #16: MDS with Assessment Reference Date of 03/31/23 was completed on 04/24/23 and was submitted and accepted into state database on 04/25/23 in Batch #2287. Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. A 100% audit on all current residents will be conducted in order to determine if they have had a Minimum Data Set Assessment completed at least once every 3 months. All residents who are identified as not having had an MDS assessment completed within the required timeframe at least once every 3 months will have one completed. This audit will be completed by the Regional Minimum Data Set Consultant. The audit along with necessary corrective actions including completing and submitting any necessary MDS assessments will be completed no later than 06/06/23. Systemic Changes On 05/12/23, the Regional Minimum Data Set Nurse Consultant conducted in-service training for the facility Minimum Data Set Nurse(s) on the importance of scheduling and completing a Minimum Data Set assessment for all residents at	

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F 638	Continued From page 2	F 638	least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education emphasized that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus was also placed on the importance of ensuring that all Minimum Data Set assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual. Monitoring The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements; The Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 6 months to validate whether or not they have had a Minimum Data Set assessment completed at least once every 3 months per the Resident Assessment Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled “Quarterly Completion of Minimum Data Set Assessments.” This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality	

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F 638	Continued From page 3	F 638	Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Rehab Director, Health Information Manager, Dietary Manager, and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 06/06/23	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		6/6/23

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F 655	Continued From page 4 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a baseline care plan including nutrition recommendations and provide a summary of the baseline care plan to residents or their representatives for 1 of 1 resident reviewed for baseline care plans (Resident #85). The findings included: Resident #85 was admitted to the facility on 2/11/23 with diagnoses that included dementia. Review of Resident #85's baseline care plan with a review date of 3/22/23 revealed no nutrition or dietary goals.	F 655	F-655 Baseline Care Plan Corrective action for affected residents: Resident #85: Resident expired on 02/20/23 which was prior to the survey date when the problem was identified; therefore, corrective action unable to be completed. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be impacted by the alleged deficient practice.	

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F 655	Continued From page 5 During an interview with the facility social worker on 4/19/23 at 9:19 AM she stated she had been in the role since January 2023, and she was responsible for baseline care plans. She reported the dietary/nutrition goal not being included on the baseline care plan must have been an oversight. The social worker stated she was not aware of the requirement for the resident or resident representative to receive a written summary of the baseline care plan. She revealed she had been reviewing them either in person or over the telephone and had not been providing written summaries. During an interview on 4/20/23 at 9:35 AM the Administrator stated the facility Social Worker was new in her role and was learning her responsibilities. He stated baseline care plans should be completed as required in the federal regulations.	F 655	A 100% audit of all current residents who have been admitted to the facility within the last 30 days will be completed in order to determine if the baseline care plan requirement was met for each of them. Audit will be completed by the Regional Minimum Data Set Consultant and corrective actions taken for any current resident identified as not having baseline care plan requirement met. Initial audit and all corrective actions will be completed no later than 06/06/23. Systemic Changes On 05/12/23, the Regional Minimum Data Set Nurse Consultant provided education to the Minimum Data Set Coordinator. This education reviewed CMS requirements for ensuring that the Baseline Care Plan requirement be met for all newly admitted residents. Baseline Care Plan Requirement: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must: 1. Be developed within 48 hours of a resident's admission. 2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: ¿ Initial goals based on admission	

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F 655	Continued From page 6	F 655		

orders.
¿ Physician orders.
¿ Dietary orders.
¿ Therapy services.
¿ Social services
¿ PASARR recommendation, if applicable.

Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

The Director of Nursing, Administrator or designee will review 5 random residents who have been admitted to the facility

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F 655	Continued From page 7	F 655	during the past 30 days in order to determine if the Baseline Care Plan was completed during the required timeframe. This audit will be completed using the Quality Assurance audit tool entitled "Baseline Care Plan Completion Audit." This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 06/06/23	
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	F 657		6/6/23

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F 657	Continued From page 8 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. (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, resident representative interview and staff interviews, the facility failed to revise a care plan to include a physician's ordered intervention for 1 of 4 residents reviewed for dialysis (Resident #14) and to conduct a quarterly care plan meeting with the resident representative for 1 of 1 resident reviewed for care plan meetings (Resident #20). Findings included: 1. Resident #14 was admitted to the facility on 3/1/2022, and diagnoses included end stage renal disease. A physician order dated 12/26/2022 for Resident #14 indicated the resident was to receive breakfast before leaving for dialysis due to sugars dropping during treatments. The annual Minimum Data Set dated 3/9/2023	F 657	F657 Care Plan Timing and Revision Corrective Action for Affected Residents: Corrective Action for Resident #14: The care plan for resident #14 was revised in order to include that he should be offered an early breakfast tray prior to leaving facility to go to dialysis treatments. This revision was made by the MDS Consultant on 05/16/2023. Corrective Action for Resident #20: The social worker has scheduled a care plan conference with the resident and his representative for May 23, 2023. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 657	Continued From page 9 indicated Resident #14 was cognitively intact, required limited assistance of one person with eating and received dialysis. The care plan for Resident #14 included a focus area for dialysis initiated on 11/25/2020 and last revised on 3/21/2023. Resident #14 receiving a breakfast meal tray before leaving for dialysis was not included as an intervention for dialysis. A focus area for nutrition initiated on 11/20/2020 and last revised on 2/12/2023 on Resident #14's care plan included a revised intervention dated 3/29/2023 to provide, set up and serve diet as ordered. Resident #14 receiving a breakfast meal tray before leaving for dialysis was not included as an intervention for nutrition. In an interview with Resident #14 on 4/17/2023 at 12:39 p.m., he stated he was not ever served a breakfast meal prior to departing the facility for dialysis. In an interview with the Dietary Manager on 4/20/2023 at 3:00 p.m., he stated the Registered Dietician was responsible for completing and updating the dietary care plan for Resident #14. On 4/20/2023 at 3:12 p.m. in a phone interview with the Registered Dietician, she stated the Dietary Manager and the MDS nurse were responsible for completing and updating Resident #14's dietary care plan that included receiving a breakfast meal tray prior to leaving for dialysis. In a phone interview with MDS Consultant on 4/20/2023 at 5:47 p.m., she stated the dietary staff was responsible for completing and updating the dietary care plan for Resident #14 on the comprehensive care plan.	F 657	All residents have the potential to be impacted by the alleged deficient practice. • A 100% audit will be conducted on all current residents who currently receive dialysis treatments to ensure that their care plan includes individual nutritional needs. This audit will be completed by the MDS nurse and all residents who are identified as not having current interventions related to dialysis on their care plan will have their care plan revised no later than 6/1/2023 by the social worker. • A 100% audit of all current residents will be conducted to determine whether the resident along with their representative have been invited to participate in their care planning process via meeting or teleconference during the past 90 days. This audit will be completed by the mds nurse and all residents who are identified as not having been invited to participate in their care planning process during the past 90 days will have an invitation extended to them by the facility's social worker. This will be completed no later than 6/1/2023. Systemic Changes On 05/12/23, the Minimum Data Set Nurse Consultant in-serviced the facility Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of the resident's current status and needs. Emphasis was placed on ensuring that care plans are	

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F 657	Continued From page 10 2. Resident #20 was admitted to the facility on 4/26/2021, and diagnoses included dementia, amputation of toe, diabetes mellitus, The quarterly Minimum Data Set (MDS) assessment dated 1/2/2023 indicated Resident #20 was moderately impaired cognitively. A review of Resident #20's medical record revealed the last care plan meeting was held on 11/16/2022. In an interview with Resident #20's Resident Representative on 4/17/2023 at 3:03 p.m., she stated the facility had not scheduled a care plan meeting to discuss Resident #20's care since 2022. In an interview with the Nurse Case Manager (Social Worker) on 4/20/2023 at 1:03 p.m., she stated care plan meetings were scheduled quarterly. She explained she was responsible for scheduling care plan meetings for the residents in rehabilitation, and the MDS Nurse scheduled the care plan meetings for the residents in the skilled nursing facility. She stated there was currently only one part-time MDS nurse in the facility. On 4/20/2023 at 1:45 p.m. in a phone interview with MDS Nurse #1, she stated she only worked part-time, and the full-time MDS Nurse position, which was currently vacant, was responsible for scheduling care plan meetings. She explained that in the absence of the full-time MDS Nurse, the Director of Nursing had been helping to schedule care plan meetings. In an interview with the MDS Consultant on	F 657	individualized for each resident's specific needs. This includes ensuring that the care plan accurately reflects the special dietary requirements and needs for residents who receive dialysis treatments, including the need to have breakfast offered to them early before they leave the facility to go for dialysis treatments. Frontline staff who provide direct care to residents rely on the care plan in order to provide safe and effective care. Therefore, it is critical that in addition to the routine quarterly assessment and care plan reviews and updates that are completed, that care plans also be updated and revised as a resident's condition changes. Care plan updates and revisions is an on-going process. The education also emphasized the importance all residents and their representative(s) being included in their care planning process. Residents and their representatives have a right to be included in the care planning process and should be invited to participate in their care planning conferences at least quarterly. Care planning meetings may be conducted in person or via teleconference. Care planning meetings should be documented including all who are in attendance. If a resident declines to participate or attend their conference, this should also be documented. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	

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F 657	Continued From page 11 4/20/2023 at 2:10 p.m., she stated care plan meetings were held quarterly and as needed to discuss resident's care. She explained the MDS nurse provided a list of residents for the Social Worker to schedule the care plan meetings. She stated Resident #20's last care plan meeting was 11/16/2022, and he was overdue for a care plan meeting. She explained it was an accidental oversight due to the transition of having a vacant full-time MDS position. In an interview with the Director of Nursing on 4/20/2023 at 2:40 p.m. she stated she had not helped set up a care plan meeting for Resident #20, and the Social Worker was responsible for setting up care plan meetings.	F 657	The Director of Nursing or designee will audit up to 5 current residents who receive dialysis treatments in order to determine if their care plan appropriately reflects any special nutritional/dietary needs, using the QA monitoring tool named Care Planning Revisions and Conferences QA Tool. All current residents will also be audited to determine whether or not they have been invited to participate in their care planning process during the past 90 days. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Rehab Director, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 6/6/2023	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 12 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, physician, and staff interviews, the facility failed to prevent an accident when Nurse Aide #2 performed a standing pivot transfer with Resident #11 instead of the care planned slide board transfer which caused her left leg to twist and resulted in a nondisplaced (not out of place) medial malleolus fracture (fracture of the inner bone of the ankle) and transversely oriented (bone broken perpendicular to its length). This was for 1 of 6 residents reviewed for accidents (Resident #11). The findings included: Resident #11 was admitted to the facility on 2/25/20 with diagnoses including diabetes mellitus, coronary artery disease, and heart failure. Review of the care plan dated 11/18/21 for Resident #11 revealed she had an activities of daily living (ADL) self-care performance deficit related to activity intolerance and fatigue. Interventions included: staff assistance with slide board for transfers and use slide board assistive device to transfer. The quarterly Minimum Data Set (MDS) completed on 8/19/22 indicated Resident #11 had moderately impaired cognition and required extensive assistance of one person for bed mobility. The MDS noted transfers and walking did not occur.	F 689	Past noncompliance: no plan of correction required.	

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Review of physician orders for Resident #11 revealed 1000mg (milligrams) of Tylenol was ordered on 8/22/22 three times daily osteoarthritis.

Review of the Investigation Report dated 10/4/22 revealed the incident involving Resident #11 occurred on 9/25/22, and the facility became aware of the incident on 9/27/22 at 7:18 PM. It stated Resident #11 reported that her foot got caught under the bed when nurse aide (NA #2) transferred her. The investigation summary included NA #2's statement that on 9/25/22 after lunch meal she transferred Resident #11 from the wheelchair to the bed, and she placed Resident #11's feet in between her legs to perform a standing pivot. NA #2 stated that during the transfer, Resident #11's leg got caught on her leg, and once she was in bed, Resident #11 told her that her leg hurt.

Review of a health status note dated 9/25/22 at 2:08 AM written by Medication Aide (MA) #1 revealed she was told by Resident #11 during medication pass that she had pain in her ankle area. Resident #11 told her that NA #2 was helping her get back to bed when her foot twisted during the pivot movement. MA #1 assessed Resident #11's ankle and no swelling/restriction of movement. She provided her with 750 milligrams (mg) of Tylenol and elevated her leg.

Interview with MA #1 on 4/20/23 at 11:46 AM revealed she had worked from 7:00 PM on 9/25/22 through 9/26/22 at 7:00 AM. MA #1 stated she could not recall if Resident #11 complained of pain during the shift or not. She further stated Resident #11 kept trying to get out of bed and the NA on duty was assigned to make frequent

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checks on her throughout the night. MA #1 did not indicate if she had reported this to Nurse #2 or the oncoming day shift staff.

NA #3, who worked the evening shift on 9/25/22, was interviewed on 4/20/23 at 12:13 PM. She revealed that around 4:30 PM on 9/25/22, Resident #11 did not complain of pain. NA #3 indicated Resident #11 screamed of pain in the left shin/ankle area when she was changing her after supper meal. She stated she told MA #1 immediately of the change and new onset of pain. MA #1 assessed Resident #11 and told NA #3 that she would address the issue. NA #3 indicated she was more careful with Resident #11 for the rest of her shift. When she asked Resident #11 what happened, Resident #11 told her that NA #2 was transferring her back to bed on first shift, and her foot got caught under the bed or chair. Resident #11 did not complain of pain for the remainder of the night.

An interview was attempted with NA #2, but she was not available during the investigation.

Review of the September 2022 medication administration record (MAR) for Resident #11 revealed MA #1 administered scheduled Tylenol on 9/25/22 at 9:00 PM with a 1/10 pain scale assessment.

Nurse #2 was interviewed on 4/20/23 at 10:44 AM. She revealed she discovered new onset of pain in Resident #11's left leg during her morning shift. She then verbally notified NP #1, who happened to be in the facility, of Resident #11's pain on the morning of 9/26/22.

The following orders were created on 9/26/22:

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oxycodone 5mg every 4 hours as needed (PRN) for pain for 14 days and a portable left hip x-ray for pain and decreased range of motion (ROM).

Nurse #2 noted a pain scale of 3/10 at 9:00 AM and 2:00 PM when the scheduled Tylenol was administered on 9/26/22.

Review of Nurse Practitioner (NP) #1's assessment of Resident #11 on 9/26/22 revealed she complained of severe left hip pain. Resident #11 told her the hip area hurt constantly but was worse with any movement. Resident #11 reported it started to hurt when she was assisted back to bed from the wheelchair by a staff member. NP #1 ordered an x-ray of the left hip and prescribed oxycodone 5 mg every 4 hours PRN (as needed) for pain.

An interview with NP #1 was conducted on 4/18/23 at 2:36 PM, and she revealed she had assessed Resident #11 on 9/26/22 in the morning when she was first notified by Resident #11 of the incident. NP #1 stated she told Nurse #2 on 9/26/22 before noon to order the x-ray, and the x-ray order was placed at 10:09 AM, and it was not uncommon for a 24-hour turnaround for the mobile x-ray company. NP #1 indicated if she had suspected a femur fracture, she would have sent Resident #11 to the emergency room (ER). During the 9/26/22 assessment, Resident did not express exacerbating pain for an urgent response. She stated she had never seen Resident #11 in what appeared to be excruciating pain, and she was treated with Tylenol as ordered for osteoarthritis and pain medication before she was sent to hospital on 9/27/22. Resident #11 was normally bed bound.

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Continued review of Resident #11's MAR revealed the pain scale was also noted as a 4/10 for both Tylenol administrations at 9:00 AM and 2:00 PM on 9/27/22. Oxycodone was not administered to Resident #11 on 9/26/22.

Review of the 9/27/22 mobile x-ray results performed at the facility prior to Resident #11's discharge to the hospital revealed an osteochondral (damage to cartilage and underlying bone) fracture of the medial femoral condyle (the inner rounded prominence at the end of the leg bone) of unknown age.

Review of a provider note dated 9/27/22 revealed they had received a call from Nurse #2 with x-ray results of an "osteochondral fracture of the medial femoral condyle of indeterminate age." There was significant swelling to Resident #11's left lower leg, and an order was created to send her to hospital.

Resident #11 received a dose oxycodone 5 mg on 9/27/22 at 3:44 PM due to a 4/10 pain scale assessment.

Resident #11 was sent to hospital emergency room (ER) on 9/27/22 at 7:18 PM.

Review of the ER notes from 9/27/23 revealed Resident #11's x-ray results showed a medial malleolus fracture transversely oriented, nondisplaced. Orthopedics was consulted and recommended Resident #11's left leg be placed in a posterior splint with a stirrup, remain non-weight bearing, and follow up with orthopedics. Pain medication was prescribed as needed, and Resident #11 was discharged back to the facility on 9/28/22.

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During an interview with the Director of Nursing (DON) on 4/20/23 at 12:28 PM, she revealed she was not the DON at the time of the incident on 9/25/22. The DON stated NA #2 should have followed the care plan for Resident #11 and used the slide board during all transfers.

The interim Administrator was interviewed on 4/20/23 at 1:37 PM, and he revealed NA #2 should have used the slide board for all transfers as it was stated in Resident #11's care plan.

The facility provided the corrective action plan with a compliance date of 10/24/22.

On 9/27/2022 the resident was sent to emergency room for eval and treatment. Follow up appointments in place for 10/05/2022. Referred to therapy for eval of transfer safety on 9/29/22.
On 9/30/22 the Nurse Consultant audited change in condition and the 24-hour report for the past 7 days, reviewing residents that flagged for high to moderate risk for changes in condition and notification. This was completed on 10/1/22. The results included: 0 of 32 residents noted with change in condition that had not been identified and reported per policy.

On 9/29/22 the Nurse Consultant identified all residents that were potentially impacted by this practice. On 9/29/2022 the therapy director began an audit of the most recent Functional Mobility Program on all current residents. The information was provided to the Minimum Data Set Coordinator and the Director of Nursing for review of all care plans to ensure they contain the current recommendations. This was completed

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F 689	Continued From page 18 on 10/14/2022. The results included: 18 of 111 were not in compliance. As of 10/24/2022 all identified residents were in compliance for care plan and kardex accuracy with transfer status. On 9/30/22, the Staff Development Coordinator and Director of Nursing began inservice of all nursing staff (including agency) on Transfer Safety and Kardex Utilization policy. This training will include all current staff including agency. The training included: accessing the Kardex prior to the initiation of care and following the Kardex plan of care. As of 10/5/2022, 23 staff members have not attended the in-service. The Director of Nursing will ensure that any of the above-identified staff who did not complete the in-service training by 10/ 5/ 2022 will not be allowed to work until the training is completed. All new employees, including agency, will be educated on accessing the Kardex prior to the initiation of care and following the Kardex plan of care. The Director of Nursing will monitor residents transfer status and Kardex utilization weekly for 2 weeks and monthly for 3 months or until resolved for compliance with the process. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		6/6/23

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F 690	Continued From page 19 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Nurse Practitioner interview, and physician interview, the	F 690	The statements made on this plan of correction are not an admission to and do	

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F 690	Continued From page 20 facility failed to discontinue an antibiotic medication administered to treat a urinary tract infection (UTI) after the organism was identified as resistant to the medication on the laboratory report dated 02/24/23 for 1 of 3 residents reviewed for UTIs, Resident #32. Findings included: Resident #32 was admitted to the facility on 03/25/19. She was diagnosed with a UTI on 02/24/23. Review of a significant change Minimum Data Set assessment dated 02/27/23 revealed she had severely impaired cognition. She required extensive assistance with activities of daily living. She had an indwelling urinary catheter. She was frequently incontinent of bowel. She received an antibiotic medication on 7 of the days during the assessment look back period. She had a life expectancy of less than six months and received Hospice care. Review of the care plan for Resident #32 dated 03/01/23 included a focal areas: (1) Increased risk for UTI due to a history of recurrent UTIs and a chronic indwelling catheter. The goal was for her risk for development of a UTI to be minimized through the current interventions for 90 days. Intervention included to encourage and assist the resident with drinking fluids throughout the day; observe for signs of a UTI and report to the physician if noted; report to the nurse if any of the following are noted: fever, pain or burning upon voiding, foul odor to urine or a change in mental status; and a urology referral as needed. (2) Antibiotic therapy with risk for adverse side effects and infection. The goal was for the	F 690	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 Bowel/Bladder Incontinence, Catheter, UTI The facility failed to discontinue an antibiotic medication administered to treat a urinary tract infection after the organism was identified as resistant to the medication on the lab report dated 02/24/2023 for resident # 32. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2 /22 /2023 the Director of Nurses received the Culture and Sensitivity report for Resident #32 with provider notification and review. Resident was prescribed Levaquin on 2/24/23 to 3/01/23. New order for Doxycycline was received and initiated on 3/02/ 2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring Urinalysis for Culture and Sensitivity have the potential to be affected by this alleged deficient	

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F 690	Continued From page 21 resident to be free of any discomfort or adverse side effects of antibiotic therapy through the review date. Interventions were to administer medication as ordered, observe for possible side effects and to report pertinent laboratory results to the physician. Review of the February 2023 Medication Administration Record for Resident #32 revealed she had been administered the antibiotic Levofloxacin 750 MG (Milligrams) intravenous one time a day for a UTI for 5 days on 02/24/23, 02/25/23, 02/26/23, 02/27/23, and 02/28/23. She had also been administered the antibiotic Doxycycline 100 MG by mouth two times a day for UTI for 7 days on 03/02/23, 03/03/23, 03/04/23, 03/05/23, 03/06/23, 03/07/23 and 03/08/23. Review of the laboratory report for a urine culture and sensitivity report dated 02/24/23 revealed the growth of >100,000 Gram Positive Cocci Enterococcus faecalis (Isolate 1). The sensitivity analysis documented the organism was resistant to Levofloxicin. The report was reviewed by the Director of Nursing on 02/24/23 at 1:45 PM. In an interview with Physician #1 on 04/19/23 at 9:00 AM he stated he was well acquainted with Resident #32 but that her primary provider was Nurse Practitioner #2. He noted although they collaborated, Nurse Practitioner #2 would be more familiar with her antibiotic orders. He stated the number one risk of her receiving the medication Levofloxacin was Achilles tendonitis but the resident had not developed it. He concluded the resident had not suffered any harm by receiving the Levofloxacin although it had not been effective in treating her UTI.	F 690	practice. On 4/28 /2023 the Director of Nurses and nursing team began auditing the past 14 days of Urine Culture and Sensitivity reports to ensure that an antibiotic order was initiated that was not resistant to the ordered antibiotic. This will be completed by 5/20/ 2023. The Director of Nurses and nursing team completed corrective action for those residents including notification to medical provider for clarification of orders and initiation of those orders. As of 5/21/2023 all residents were in compliance with appropriate medication management of ordered antibiotics. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Nurse Consultant/Director of Nurses will educate physician services on reviewing all culture and sensitivity reports to ensure appropriate antibiotics are ordered for treatment. This will be completed by 5/20/2023. On 5/20 /2023 the Nurse Consultant began education for the Director of Nurses and nursing team on the following topics: " Urine Culture and Sensitivity report reviews to ensure that they have been addressed by the physician and appropriate orders received and implemented timely. This information has been integrated into the standard orientation training and in the	

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F 690	Continued From page 22 In an interview with Nurse Practitioner #2 on 04/19/23 at 3:30 PM she stated when she reviewed the urine culture for Resident #23 several days after the results had come back, she switched the treatment for the UTI to Doxycycline. She explained when she had originally ordered the Levofloxacin, she had assessed the resident and thought she looked like she was "going septic" with a UTI so she started the intravenous antibiotic. She stated when the urine culture came back showing the organism was resistant to the medication, the medication should have been changed by the provider who reviewed the report. She further explained the laboratory results were in the computer on the dashboard to alert provders of the results but once a provider reviewed the results, they disappeared from the dashboard and may not be reviewed again for several days until the prescribing provider returned to the facility and asked about the outcome of the report, which is what happened in this case. She stated this had happened several times. She noted when she had returned several days later the next week, she had asked about the report and she switched the antibiotic to Doxycycline. She concluded that by receiving the Levofloxacin which the organism was resistant to could have allowed further growth of the bacteria and the outcome would be that the UTI would not clear as fast. In an interview with the Director of Nursing on 04/19/23 at 4:10 PM she stated she was not aware that when a laboratory report was reviewed on the computer it disappeared from the dashboard and providers were no longer alerted to the results. She thought the providers would still see the results and she had not reported the	F 690	required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 6/5/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F690 Quality Assurance Tool for compliance with the Laboratory Results Review Process related to Urine and Culture Sensitivity Reports and initiation of appropriate antibiotic orders weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor 4 Urine Culture and Sensitivity Reports to ensure an appropriate antibiotic is ordered with follow through of physician review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 690	Continued From page 23 results to the Nurse Practitioner or the physician when she reviewed the results for the urine culture on 02/24/23.	F 690	Date of Compliance: 06/06/2023	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, staff interviews and a dialysis center staff interview, the facility failed to provide 1 of 7 residents (Resident #14) reviewed for nutrition a breakfast meal and a snack before departure from the facility for a dialysis appointment. Findings included:	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	6/6/23

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F 692	Continued From page 24 Resident #14 was admitted to the facility on 3/1/2022, and diagnoses included Diabetes Mellitus and end stage renal disease. The annual Minimum Data Set (MDS) assessment dated 3/9/2023 indicated Resident #14 was cognitively intact, required limited assistance of one person with eating and total assistance of one person moving on and off the unit. The MDS also stated Resident #14 received dialysis. Resident #14's care plan included a focus area for hemodialysis (dated revised 3/21/2023) for three times a week and nutrition (dated revised 2/12/2023). Interventions for nutrition included providing, setting up and serving diet as ordered. Resident #14's care plan for activities of daily living revealed Resident #14 was able to feed himself independently and needed assistance in setting up meal trays. A review of the Long Term Care (LTC)/Dialysis Communication form dated 12/24/2022 revealed the following new orders: please feed breakfast before patient comes to dialysis his blood sugars have been dropping during treatments. Physician orders included an order dated 6/28/2023 for dialysis on Tuesday, Thursday and Saturday at the dialysis center and an order for a regular textured liberalized renal and low concentrated sweet (LCS) diet with 1200 milliliters fluid restriction daily. There was also an order dated 12/26/2023 for Resident #14 to receive breakfast before leaving for dialysis due to blood sugar dropping during treatment. There was no order on the Medication	F 692	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 692 1. Immediate action(s) taken for the resident(s) found to have been affected include: Based on record review, observation, resident interview, staff interviews, and a dialysis staff interview, the facility failed to provide 1 of 7 residents (Resident # 14) reviewed for nutrition a breakfast meal and a snack before departure from the facility for a dialysis appointment. Corrective action was taken for Resident 14 on April 20th. Dietary Manager prepared a breakfast tray for him prior to his departure for dialysis. The Dietary Manager arrives at the facility daily by 5:00am to prepare trays for dialysis residents and to prepare snacks for residents to eat while waiting for transportation to dialysis. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All dialysis residents have the potential to be affected by the deficient practice. List of current dialysis residents is kept posted in the kitchen. Dietary manager will note incoming dialysis residents during daily meetings which address new admissions or care plans and incorporate into the new residents diet plan and meal	

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F 692	Continued From page 25 Administration Record (MAR) from December 2022 to April 2023 for Resident #14 to receive a breakfast meal prior to leaving for dialysis. The April 2023 MAR showed Resident #14 received a diabetic snack at bedtime, finger stick blood sugars were checked twice a day (at 6:00 a.m. and 9:00 p.m.), and he received no diabetic medications to control his Diabetes Mellitus. Resident #14's blood sugar scheduled at 6:00 a.m. ranged from 74 to 129 in April 2023. A review of Resident #14's meal ticket included the following information: fluid restriction 1200 milliliters, LCS DM (Diabetes Mellitus) liberalized renal diet, dialysis on Monday, Wednesday and Friday, set up and observe, dislikes: oatmeal and standing orders for 4 ounces of fruit juice and 6 ounces of coffee. There was no reference to Resident #14 receiving a breakfast tray before leaving for dialysis in the dietary notes. In an interview with Resident #14 on 4/17/2023 at 12:39 p.m., he stated he was scheduled for dialysis at 8:00a.m. on Tuesday, Thursday, and Saturday and received no breakfast meal or a snack to take to dialysis prior to departing the facility for dialysis. On 4/18/2023 at 06:20 a.m., Resident #14 was observed lying in bed awake with no breakfast tray in the room. There were no food items on the bedside table. On 4/18/2023 at 06:59 a.m., Resident #14 was observed on a stretcher leaving the facility with a transport team. Resident #14 stated he had not received a breakfast meal or a snack that	F 692	prior to dialysis. 3. Systemic changes. In-Service education was provided to all full time, part time, and as needed dietary staff on 4/19/23 by Dietary Service Director on meal prep for dialysis residents. 4. Quality Assurance monitoring procedure. The Administrator will monitor this process by auditing breakfast meals for dialysis residents weekly x 4, then monthly x 2. Results will be reported to and reviewed with QA Committee on a monthly basis. Corrective action completion date: 6/06/2023	

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morning, and there were no food items transported with Resident #14.

In an interview with Nurse #7 on 4/18/2023, she stated the transport team usually came between 6:00 a.m. to 6:30 p.m. to pick up Resident #14 for his dialysis appointments. She stated the nursing staff usually woke him up around 5:00 a.m. to assist with his bath and dress, she prepared his medications and packet to go with the resident. When asked if Resident #14 received a meal before leaving for dialysis, she stated he was given a snack if he wanted one and she didn't know if Resident #14 received a snack that morning.

In a phone interview with Nurse Aide #4 on 4/19/2023 at 11:53 a.m., she stated on 4/17/2023 she worked the 11:00 p.m. to 7:00 a.m. shift and was assigned to Resident #14. She said the dietary staff were not at the facility before Resident #14 left for dialysis and Resident #14 had never received a breakfast tray before leaving for dialysis. She explained she did not offer Resident #14 a breakfast meal or snack for dialysis the morning of 4/18/2023 because the facility did not have snacks prepared for Resident #14 before leaving for dialysis or to take to his dialysis appointment, and there were no breakfast items in the facility's nourishment room for residents.

On 4/18/2023 at 1:11 p.m. in an interview with the Dietary Manager, he stated there was no dietary staff in the facility before 6:00 a.m. and delivery of breakfast meals started at 7:20 a.m. He said there were snacks in the nourishment refrigerator for Resident #14 if he was leaving before 6:00 a.m. He shared dietary dialysis list dated October

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12, 2022. Resident #14 was listed with instructions noted beside his name to arrange transportation for dialysis on my scheduled days. There was no information on the dietary dialysis list for Resident #14 to receive a breakfast tray before leaving for dialysis. Handwritten at the bottom of the dietary dialysis list was Tuesday, Thursday and Saturday which the Dietary manager explained were the days when Resident #14 went to dialysis. He explained meal tickets were printed in the dietary department and he could only enter diet orders and stated the nursing staff entered the days for dialysis. He further explained how the dietary staff had stopped preparing dietary snacks a couple months ago for Resident #14 because he could not eat during transportation to the dialysis center and at the dialysis center. In a follow up interview with Dietary Manager on 4/20/2023 at 3:00 p.m., he stated dietary orders were communicated from the nursing staff on dietary slips, and the dietary manager entered the information into the dietary system. He said he did not have a dietary slip for Resident #14 to receive a breakfast tray before leaving for dialysis because he did not keep dietary slips from December 2022.

On 4/18/2023 at 1:31 p.m. in an interview with the Director of Nursing, she stated had a separate system for entering dietary information, and dietary was responsible for entering information for Resident #14's dietary meal ticket. She stated she didn't know why Resident #14 didn't receive a meal tray or a snack for dialysis, and Resident #14 should have received something to eat before leaving for dialysis.

On 4/18/2023 at 3:00 p.m. in an interview with Resident #14, he stated he could not eat the

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lunch meal tray that was in his room when he returned from dialysis because he didn't like the contents on the tray and was feeling tired. He stated the nursing staff had not offered Resident #14 an alternative meal, and he had not asked for anything to eat. Resident #14 stated he had not eaten anything while at the dialysis center.

On 4/19/2023 at 10:29 a.m. in an interview with dialysis center nurse, she stated Resident #14 was not allowed to eat while in the dialysis chair from 8:00 a.m. to 12:00 p.m. She said Resident #14 had informed the dialysis team previously that he was not receiving breakfast before leaving the facility and had requested Resident #14 receive a breakfast meal prior to dialysis. She explained Resident #14 could eat a snack, if provided, while waiting for the transport team after receiving dialysis.

On 4/19/2023 at 10:37 a.m. in a phone interview with Nurse #8, she stated the dialysis center had requested Resident #14 to receive a breakfast tray before leaving for dialysis because his blood sugar was dropping during dialysis treatments. She stated she didn't know why Resident #14 was not getting his breakfast. In a follow up phone interview on 4/19/2023 at 11:45 a.m., Nurse #8 explained the order for a breakfast tray before leaving for dialysis would have been written on a dietary slip and given to the dietary department. She stated the order would not have been placed on the MAR for nursing and could not recall if she completed the dietary skip for the dietary department.

On 4/20/2023 at 3:12 p.m. in a phone interview with the Registered Dietician, she stated Resident #14 not receiving a breakfast tray before leaving

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F 692	Continued From page 29 for dialysis was a concern because Resident #14 not eating could lead to his blood sugar dropping and effect the management of his diabetes mellitus. She stated Resident #14 should have received a prepared snack to take to dialysis to eat while waiting for the transport team.	F 692		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		6/6/23

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F 756	Continued From page 30 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and a Pharmacy Consultant interview, the facility failed to act on a pharmacy recommendation to draw a laboratory test on a monthly medication review written by the Consultant Pharmacist #1 for 1 of 6 residents reviewed for unnecessary medications (Resident #77). Findings included: Resident #77 was admitted to the facility on 12/2/2022, and diagnoses included hypothyroidism (occurs when the thyroid gland doesn't make enough thyroid hormones to meet your body's needs). Resident #77's care plan dated 12/4/2022 included a focus for hypothyroidism and indicated Resident #77 was receiving Levothyroxine Sodium (a hormone that is used to treat a condition called hypothyroidism) daily and was at risk for adverse side effects. Interventions included administering Levothyroxine Sodium per physician's order and reporting critical labs to the physician as soon as possible. A Thyroid-Stimulating Hormone (TSH) laboratory test dated 1/18/2023 reported Resident #77's TSH level was high at 10.8. (Normal TSH values	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 The facility failed to act upon recommendations made by the Pharmacy Consultant for resident #77. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident# 77, on 4/21/2023 a thyroid stimulating hormone (TSH) lab was ordered and obtained. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 756	Continued From page 31 are 0.27milli-international units per liter (mIU/L) to 4.20mIU/L and a TSH level of 10mIU/L or higher is typically indicative of hypothyroidism). Physician orders dated 1/20/2023 included an order to increase Levothyroxine Sodium from 112 micrograms (mcg) to 125 mcg once a day for hypothyroidism. Consultant Pharmacist #1 wrote the following pharmacy recommendations for Resident #77: * On 2/7/2023, there was a request to please consider ordering the following labs to follow current medication therapy: TSH around 3/6/2023 to follow up with the 1/20/2023 dose change of Levothyroxine Sodium. The physician note dated 3/2/23 stated there had been adjustments in the dose of the thyroid medication, and TSH levels would be repeated to assess for further dosing changes of the thyroid medication. There was no documentation on the pharmacy recommendation indicating staff had acted on the recommendation. * On 3/8/2023, there was no recommendation on the pharmacy recommendations for a TSH laboratory test. * On 4/6/2023, there was a recommendation for a TSH laboratory test to be conducted. There was no documentation on the pharmacy recommendation indicating staff had acted on the recommendation. A review of Resident #77 medical record revealed no order for a TSH laboratory test after 1/18/2023 and any further TSH laboratory results for Resident #77. The quarterly Minimum Dat Set (MDS) assessment dated 3/11/2023 indicated Resident	F 756	All residents have the potential to be affected by the alleged deficient practice. As of 5/12/2023 the Director of Nurses and nursing team began auditing of all pharmacy consultant recommendations for the last 30 days to assure that recommendations made by the pharmacy consultant have been reviewed by the physician and have been implemented as ordered. This will be completed by 5/20/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/20/2023 the Director of Nurses began education for the Assistant Director of Nursing and nurse management team on the following topics: • Drug regimen reviews should include an audit of the monthly pharmacy consultant recommendations to assure that they have been addressed by the physician and orders received as a result of recommendations have been implemented timely. • Drug regimen reviews are uploaded to the individual resident documents once all steps in the process have been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not	

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F 756	Continued From page 32 #77 was cognitively impaired severely and had a diagnosis of hypothyroidism. A review of Resident #77's March 2023 and April 2023 Medication Administration Records revealed she was receiving Levothyroxine Sodium 125mcg daily. On 4/20/2023 at 10:35 a.m. in a phone interview with Pharmacy Consultant #1, she stated pharmacy recommendations were emailed to the Administrator and the Director of Nursing to communicate recommendations to the physician and nursing staff. She stated the pharmacy preferred recommendations to be resolved by the next monthly medication review, and if not address, the Pharmacy Consultant would submit the recommendations again. On 4/20/2023 at 4:20 p.m. in an interview with the Director of Nursing (DON), she stated pharmacy recommendations were emailed to the DON from the pharmacy. She explained the clinical team (the DON and a support person who was not one specific nurse) tried to review and respond to the pharmacy recommendations as soon as they were received. She stated pharmacy recommendations were initialed at the bottom to indicate the recommendations had been addressed. She stated she did not know why the pharmacy recommendations dated 2/7/2023 and 4/6/2023 had not been done, and she would check with the physician about ordering the TSH laboratory test.	F 756	receive scheduled in-service training will not be allowed to work until training has been completed by 6/5/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F756 Quality Assurance Tool for compliance with the Pharmacy Recommendation Review Process weekly x 4 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor for follow through of physician review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/06/2023	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		6/6/23

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F 757	Continued From page 33 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to discontinue an antibiotic medication as directed by the hospital emergency department because the identified organism in the urine culture was resistant to it for 1 of 5 residents reviewed for unnecessary medication administration, Resident #141. Findings included: Resident #141 was admitted to the facility on 04/07/23 with diagnosis of a urinary tract infection (UTI). An admission Minimum Data Set (MDS)	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. The facility failed to discontinue an antibiotic medication as directed by the hospital emergency department for	

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F 757	Continued From page 34 assessment was in progress and incomplete. The assessment documented Resident #141 had severely impaired cognition. The care plan for Resident #141 revised on 04/17/23 documented the following focal area: Antibiotic therapy with a risk for adverse side effects related to a UTI. The goal was for Resident #141 to be free of any discomfort or adverse side effects of antibiotic therapy through the next review date. Interventions were to administer medication as ordered and to observe for possible side effects every shift. Review of the Emergency Department Instructions for Resident #141 dated 04/14/23 documented the resident had been evaluated at the hospital for abdominal pain. Diagnoses included lower abdominal pain, vesicular rash and UTI. Laboratory tests in progress included a Urine Reflex Culture, clean catch. Changes to her medication list included to start Cefdinir 300 MG (Milligrams) Capsule, take (1) capsule (300 MG total) by mouth two times a day for 7 days. Review of April 2023 physician orders for Resident #141 revealed the following orders: (1) Levaquin 250 MG give one tablet by mouth one time a day for UTI for 7 days, dated 04/16/23, ordered and created by Physician #1; and (2) Cefdinir Capsule 300 MG give one capsule by mouth two times a day for UTI for 7 days, dated 04/17/23, ordered by Physician #1 and created by Nurse #1. The April 2023 Medication Administration Record for Resident #141 documented she had received Cefdinir 300 MG on 04/17/23, 04/18/23, 04/19/23 and 04/20/23 and Levaquin 250 MG on 04/17/23,	F 757	Resident #141. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #141, on 4/17/2023 the physician discontinued the antibiotic medication Cefdinir due to resistance to the identified organism in the urine culture. Levaquin was ordered by the physician for the urinary tract infection on 4/16/2023 and administration initiated as ordered. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents being admitted or readmitted from the hospital have the potential to be affected by this alleged deficient practice. On 5/12 /2023 the Director of Nurses and nursing team began auditing the past 7 days of admissions/readmissions to assure all orders were implemented as indicated by the hospital discharge summary documents and that the orders were confirmed or further clarified with the facility attending physician. The results were: all residents were in compliance with appropriate medication management ordered for antibiotic medication. This will be completed by 5/20/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/ 20/2023 the Director of	

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F 757	Continued From page 35 04/18/23 and 04/19/23. In an interview with Nurse #3 on 04/20/23 at 1:30 PM she stated she had received a call from the hospital on 04/16/23 requesting to speak to the physician regarding the medication orders for Resident #141. She noted she gave the caller the on-call number for the physician. She recalled later that day Physician #1 called her and stated he had put orders in place that needed to be confirmed. She stated she confirmed two medication orders-one for an antifungal medication and one for the antibiotic Levaquin. In an interview with Physician #1 on 04/20/23 at 2:40 PM he stated the hospital had called him on Sunday, 04/16/23, with an urgent message to discontinue the previous order for Cefdinir for Resident #141 because the urine culture had come back indicating the organism was resistant to Cefdinir. They instructed him to order Levaquin instead. He noted he went into the computer to order the Levaquin and to discontinue the Cefdinir, but he could not discontinue the Cefdinir because it wasn ' t there, so he entered the order for the Levaquin. He confirmed he had never ordered the medication Cefdinir, only Levaquin, for Resident #141. He stated he was on call that day and was not the attending physician for Resident #141. In an interview with Nurse #1 on 04/20/23 at 4:13 PM by telephone she stated she did not remember ordering Cefdinir 300 MG for Resident #141 on Monday, 04/17/23, because that day was hectic with two residents who had coded and required CPR (Cardiopulmonary Resuscitation). She reported her normal routine when she received orders from an emergency department	F 757	Nurses/Assistant Director of Nurses began education of all licensed nurses (full time/part time and as needed) and agency nurses on the admission/readmission physician order process and clarification of orders with the physician. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 6/5/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F757 Quality Assurance Tool for compliance related to the order process for admissions/readmissions and clarification/confirmation of orders with the physician as part of the Daily Clinical Review Process weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing/designee will monitor 4 admission/readmissions to ensure the physician clarification order process was implemented to avoid unnecessary drug administration. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to	

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F 757	Continued From page 36 was to enter the orders into the computer system and the physician would be alerted electronically "somehow" and approve the orders. She noted she was not quite sure how that happened, but she did not routinely call a physician to obtain a verbal order before ordering medications listed on a discharge summary. She would then put the printed copy of the discharge summary in the physician communication box and the Medical Records box who in turn faxed the orders to the physician ' s office. In an interview with the Medical Director on 04/20/23 at 4:30 PM he stated he was the attending physician for Resident #141. He stated he had been at the facility earlier looking over records and noticed Cefdinir had been ordered in error on 4/17/23 for Resident #141 so he discontinued it. He commented he had spent a half hour reviewing her record trying to figure out why the resident was on two antibiotics for the same UTI. He concluded the nurse on Monday had seen the order for Cefdinir on the discharge paperwork from the emergency department but didn ' t have the benefit of the knowledge from the emergency department phone call to Physician #1 and ordered the medication on Monday. He concluded that because the resident was also receiving the antibiotic Levaquin (that the organism was susceptible to) the UTI was being treated. He also stated receiving both medications at the same time would not hurt the resident. In an interview with the Director of Nursing on 04/20/23 at 3:55 PM she stated whenever orders were received from an emergency department the physician was to be notified so he or she could either approve the order or decline it. She	F 757	ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/06/2023	

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F 757	Continued From page 37 noted after receiving a verbal order, the nurse would put the order into the computer system, a second nurse would check the order, and a third check would be done in the morning meeting. She confirmed all orders had to be approved by a physician before putting the order into the system.	F 757		
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--- §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	F 758		6/6/23

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F 758	Continued From page 38 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, staff interview and a Pharmacy Consultant #1 interview, the facility failed to ensure physician orders for an as needed (prn) psychotropic medication (a medication that affects the brain and mental processes) was time limited to a maximum duration of 14 days for 1 of 6 residents reviewed for unnecessary medications (Resident #77). Findings included: Resident #77 was admitted to the facility on 12/2/2022, and diagnosis included dementia with delusions. Resident #77's care plan dated 12/4/2022 included a focus for receiving antipsychotic medications related to dementia with delusions. Interventions included consulting the pharmacist to review psychotropic medications quarterly and	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F758 The facility failed to ensure physician orders for an as needed psychotropic medication was time limited to a maximum duration of 14 days for Resident 77.	

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F 758	Continued From page 39 as needed for possible changes and reductions in medications. The quarterly Minimum Data Set (MDS) assessment dated 3/11/2023 indicated Resident #77 was severely cognitively impaired and had received antianxiety medications for seven days in the 7-day look back period. The MDS also indicated Resident #77 was receiving antipsychotics on a routine basis. Physician orders dated 3/20/2023 included an order for Risperdal (antipsychotic medication that works by changing the effects of chemicals in the brain) 0.5 milligrams(mg) as needed at bedtime for agitation and anxiety related to Dementia for 30 days. Pharmacy recommendations dated 4/6/2023 made by the Pharmacy Consultant #1 revealed there was no recommendation to change the order for Risperdal 0.5mg prn for 30 days. A review of Resident #77's April 2023 Medication Administration Record revealed she only received one prn dose of Risperdal 0.5mg at bedtime on 4/13/2023. In a phone interview with the Pharmacy Consultant #1 on 4/20/2023 at 10:35 a.m., she stated orders for prn antipsychotics could not extend beyond 14 days. After reviewing Resident #77 orders for Risperdal 0.5mg prn for 30 days and Resident #77's report from the monthly medication review conducted on 4/6/2023, she stated she recorded the Risperdal was ordered for 14 days and did not notice it was ordered instead for 30 days. She said antipsychotics ordered for 30 days prn needed to be addressed,	F 758	1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #77, was noted with an order for as needed (PRN) psychotropic medication without a stop date of 14 days. On 4/19/2023 the Director of Nursing notified the medical provider and the medication was discontinued by the medical provider on 4/19/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 5/9 /2023 the Director of Nursing/Assistant Director of Nurses began auditing all current as needed (PRN) psychotropic medication orders to ensure they contain a 14 day stop date. This process was completed on 5/14/2023. The results were: all residents were in compliance with appropriate medication management of ordered for psychotropic medication. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/20/2023 the Director of Nursing and Staff Development Coordinator began education on the resident's right to be free from unnecessary psychotropic medications/ PRN use and the need for a 14 day stop date with assessment by the physician for continued utilization for all licensed nurses including agency nurses. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 758	Continued From page 40 and she would ask the physician to change the order to 14 days prn. In an interview with the Director of Nursing on 4/20/2023 at 2:26 p.m., she stated the clinical team (the DON and a support person) checked antipsychotic orders daily Monday through Friday for prn antipsychotic orders. She explained prn antipsychotic orders should only be for 14 days, and Resident #77's Risperdal 0.5mg prn for 30 days written on 3/20/2023 was missed by the clinical team on daily checks.	F 758	all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 6/05/2023, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F758 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. All as needed (PRN) psychotropic medications will be reviewed to ensure that the 14 day stop date period is in compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance unnecessary medications and psychotropic medications. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/06/2023	

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F 761	Continued From page 41	F 761		
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 §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 observation and staff interviews the facility failed to record an opened date on 3 of 4 insulin pens and failed to discard 1 of 1 expired insulin pens on 1 of 2 medication carts (700 Hall) observed for medication storage, failed to discard a tablet laying in the 100 hallway and left medications at the bedside for 2 of 2 residents who had not been assessed for safety of self-medication (Resident #33 and Resident #63).	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all	6/6/23

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F 761	Continued From page 42 Findings included: 1. The manufacturer's recommendations for Lantus insulin storage was for Lantus insulin to be discarded 28 days after opening even if there was insulin left. An observation of the 700 Hall medication cart was made on 04/19/23 at 11:45 AM with Nurse #3 present. The following open insulin pens were in the top drawer of the cart: (1) Lantus insulin pen with no opened date, (1) Lispro insulin Kwikpen with no opened date, (1) Novolog insulin pen with no opened date, and (1) Lantus insulin pen with an opened date of 03/16/23, which according to the manufacturer recommendations had expired on 04/12/23. In an interview with Nurse #3 at the time of the observation on 4/19/23 at 11:45 AM, she confirmed the (3) insulin pens with no open date and the expired Lantus insulin pen were opened and in use. She stated all insulin pens were to be dated when opened to enable staff to determine the expiration date. She noted the Lantus insulin pen dated 03/16/23 had expired 28 days after opening and should have been discarded. She removed all 4 of the insulins pens from the cart and discarded them. In an interview with the Director of Nursing on 04/19/23 at 12:15 PM she stated all insulin pens were to be dated when opened and discarded on the expiration date. 2. During a continuous observation on 4/17/23 from 12:30 PM until 12:50 PM a white pill with	F 761	alleged deficiencies cited have been or will be corrected by the dates indicated. F 761 The facility failed to record an open date on 3 of 4 insulin pens and failed to discard 1of 1 expired insulin pens on 1 of 2 medication carts. The facility failed to discard a tablet laying on the 100 hallway floor and left medications at the bedside for 2 of 2 residents. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #33 and # 63 the medication was removed from bedside on 4/18/2023 by the assigned nurse and administered to each resident by the assigned nurse. Each resident was educated on the need for the nurse to administer all medications and observe that they have been taken by the resident by the assigned nurse. On 5/4 /2023 assessment by the nursing team did not indicate that the residents were a candidate for self-administration of their medications.On 4/17/2023 the assigned nurse discarded the pill that was found on the 100 hallway floor per facility policy. On 4/19/2023 the assigned nurse removed the non-dated and expired insulin pens on the 700 hallway cart. The medications were replaced and dated when opened for initial utilization by the assigned nurse on 4/19/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 761	Continued From page 43 210 inscribed was on the floor outside of room 110. An interview was conducted with Medication Aide #2 on 4/17/23 at 12:48 PM who stated she was unsure how a pill got onto the floor. She stated she was working as a nurse aide and had not administered any medications on 4/17/23 and stated someone should tell the nurse. During an interview with Nurse #4 on 4/17/23 at 12:54 PM she stated she was unsure why there was a pill on the floor or who may have missed their medication. She reported she was unsure of the next steps but would ask the Director of Nursing. An interview was conducted with the Director of Nursing (DON)on 4/17/23 at 1:01 PM who stated the facility physician had been contacted. She reported the facility was working to determine who may have missed a dose of their medication. The DON further stated the medication has been destroyed. 3. Resident #33 was admitted to the facility on 9/7/21 with diagnoses that included heart disease and anxiety. Her most recent Minimum Data Set assessment dated 2/17/23, a quarterly assessment revealed Resident #33 was assessed as cognitively intact. Review of Resident #33's care plan last reviewed revealed she was not care planned for self-medication administration. During an interview and observation with Resident #33 on 4/18/23 at 10:26 PM she reported she had received her evening	F 761	On 5 /11/2023 the Director of Nurses/Unit Manager audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no other residents who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. On 5/ 11 /2023 the Director of Nurses/Unit Manager audited all medication carts for any expired medications or opened insulin pens for presence of labeling with the opening date. The results were: no concerns were identified and there were no expired medications or opened insulin pens without labelling of the opening date. On 5 / 11 /2023 the Director of Nurses audited each hallway floor for the presence of any medications and no other concerns were identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/20/2023 the Director of Nurses and Staff Development Coordinator began education of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included resident assessment for self-administration of medication process and safely securing and storing medications, labeling of the	

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F 761	Continued From page 44 medications with no issue. A small cup was observed with two pink pills each had a 19 scored on one side and a Y scored on the other. Resident #33 stated the nurse had given her medications and she chose to save those two pills for closer to her bedtime. She stated some nurses will let her self-administer her bedtime medications and some will not. Resident #33 stated the medications were her bedtime dose of alprazolam. An interview was conducted with Nurse #5 on 4/18/23 at 10:30 PM who stated she gave Resident #33 her medications and thought she had taken them. During an interview and observation with Nurse #5 and Resident #33 on 4/18/23 at 10:31 PM Nurse #5 stated the medications in the cup were the ones she gave Resident #33. Resident #33 apologized to Nurse #5 and stated she should have hidden the medications when the surveyor entered the room. Review of Resident #33's Medication Administration Record revealed the medications in the cup were alprazolam 1 mg each. Record review did not reveal an assessment for self-administration of medications for Resident #33. On 4/19/23 at 9:05 AM an interview was conducted with the Interim Administrator who stated Nurse #5 should have ensured Resident #63 had taken her medications. He stated she had not been assessed to administer to self-administer her own medications.	F 761	date on opened insulin pens and checking expiration dates on medications to assure no expired medications are administered. Education will be completed by 6/05/2023. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 6/05/2023. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits of 4 resident rooms will be completed on various days of the week and shifts to assure compliance with the medication storage policy. Audits will be done daily x one week and then weekly for 2 weeks, then monthly for 3 months or until resolved for compliance with facility policy on self- administration of medication process. Quality assurance audits will be	

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F 761	Continued From page 45 4. Resident #63 was admitted to the facility on 6/14/21 with diagnoses that included diabetes mellitus. Her most recent Minimum Data Set assessment dated 12/23/22, a quarterly assessment revealed she was cognitively intact. Review of Resident #63's care plan last reviewed 11/3/22 revealed she was not care planned for self- medication administration. During an interview with Resident #63 on 4/18/23 at 10:28 PM she stated she had her bedtime medications in a cup on the dresser to her room. She reported she placed them on her dresser so her roommate could not get them. Resident #63's roommate (Resident #41) was admitted to the facility on 8/19/19 with diagnoses that included dementia. Resident #41's most recent Minimum Data Set assessment dated 1/12/23, a quarterly assessment revealed she had severe cognitive impairment. An observation was conducted in Resident #63's room and there was a medication cup on her dresser with 1 yellow tablet with a V scored into one side and a white pill with a 50/8 scored into one side. An interview was conducted with Nurse #5 on 4/18/23 at 10:30 PM who stated she gave Resident #63 her medications at the medication cart and thought she had taken them. Nurse #5 stated she did not observe Resident #63 take the medications. Review of Resident #63's Medication Administration Record revealed the medications	F 761	completed by the Director of Nurses or designee to assess that all medications are safely and appropriately stored, that all opened insulin pens are dated and no expired insulin pens are on the medication cart. Audits of medication carts, safe storage of medications, appropriate dating of insulin pens and that insulin pens are not expired will be completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality assurance Meeting is attended by the Administrator, Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manger. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 6/06/2021	

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F 761	Continued From page 46 in the cup were clonazepam.5 milligrams and trazadone 50 milligrams. Record review did not reveal an assessment for self-administration of medications for Resident #63. On 4/19/23 at 9:05 AM an interview was conducted with the Interim Administrator who stated Nurse #5 should have ensured Resident #63 had taken her medications. He stated she had not been assessed to administer to self-administer their medications.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to honor food preferences for 1 of 4 residents reviewed for food preferences (Resident #48). The findings included: Resident #48 was readmitted to the facility on 3/2/23.	F 806	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	6/6/23

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F 806	Continued From page 47 Review of the admission Minimum Data Set (MDS) assessment dated 3/1/23 revealed Resident #48 was cognitively intact, had no weight changes, and required supervision with eating. The physician orders for Resident #48 were reviewed, and a cardiac diet with regular texture was ordered on 3/2/23. During an interview with Resident #48 on 4/17/23 at 11:37 AM, she revealed she often received foods she disliked at all meals on a regular basis. During an observation on 4/18/23 at 6:12 PM, Resident #48 received a bowl of squash on her dinner meal tray. Review of Resident #48's food preferences from the dinner meal ticket on 4/18/22 revealed had classified squash/zucchini as a dislike. On 4/18/23 at 6:31 PM, Cook #1 was interviewed. She stated Resident #48 received squash on her dinner tray because she did not hear dietary aide #1 say no squash when calling out the meal tickets in the kitchen during tray service. Cook #1 indicated she tried to make sure meal trays were correct. Cook #1 could not recall hearing dietary aide #1 call squash as a dislike for Resident #48's dinner meal tray. DA #1 was interviewed on 4/18/23 at 6:33 PM, and he revealed he called out the diet and dislikes during tray line for dinner trays. He stated he had called out a dislike for squash but could not recall for which resident. During an interview with the Dietary Manager (DM) on 4/20/23 at 9:25 AM, he revealed	F 806	deficiencies cited have been or will be corrected by the dates indicated. 1. Corrective action Based on meal observations and interviews between 4/17/2023 and 04/18/2023 the facility failed to provide preferred food selections for 1 of 4 residents. It was reported and observed that resident #48 often received disliked food items on her meal tray. For resident #48 the following correction action was taken: resident's preferences have been updated to reflect her likes and dislikes. In-service was held on May 10, 2023 with dietary team to inform them of the changes made to resident 48's tray card. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff in-serviced 5/10/23 regarding accuracy of meals served and diet consistency policies. All dietary staff are being evaluated on core competencies. All current entries in Tray card will be reviewed for accuracy and modified as needed by 5/10/23. Menu selection program modified to ensure all residents that are cognitively appropriate receive menu selections and are assisted as needed with program. All residents will be interviewed to update food preferences by 6/6/2023. 3. Systemic changes	

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F 806	Continued From page 48 Resident #48 should not have received squash on her 4/18/23 dinner meal tray. He was not aware of this ongoing issue. The interim Administrator was interviewed on 4/20/23 at 10:01 AM. He revealed Resident #48 should not have received squash on her dinner meal tray. The DM was providing education daily to kitchen staff regarding accuracy of all items on meal trays. The Administrator indicated dietary staff should follow the instructions on the meal tray cards at each meal.	F 806	In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director on 5/10/23. Topics included: ¿ Tray Accuracy Education ¿ Diet Consistency and Accuracy Policies ¿ Meal Service Policies ¿ Meal Selection Program Process This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Tray card to be reviewed and modified on admissions, quarterly, and as needed by Dietary Service Director. Menus to be reviewed daily and modified per diet preferences as needed by Dietary Service Director. 4. Quality Assurance monitoring procedure. The Dietary Services Director will monitor accuracy of completed trays served to residents per Dietary Meal QA Audit weekly x4 and then monthly x 2. Tray card will be audited monthly and test trays completed monthly per policy by the Dietary Service Director. The consultant dietitian will complete quarterly diet orders. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by	

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F 806	Continued From page 49	F 806	the Ambassador Program daily and reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director.	
F 812 SS=F	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 observation and staff interviews, the facility failed to 1) label and date leftover food/drink items and clean the refrigerators/freezers in three of three nourishment rooms (nourishment room #1, #2 and #3) 2) allow meal trays to air dry prior to assemblage and stacking for two of two	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	6/6/23

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F 812	Continued From page 50 observations 3) clean the convection oven. These practices had the potential to affect all residents. The findings included: 1. a. An observation of the nourishment room in between the 500/600 halls (nourishment room #1) was conducted on 4/18/23 at 9:32 AM, and the refrigerator/freezer were inspected. The following items were found inside the refrigerator without a date or label: 1 opened jar of spinach dip, 1 opened gallon container of tea, 1 half-eaten piece of bread wrapped in a saturated paper towel, 1 black plastic bag containing a to go container with half eaten food, 1a white plastic bag containing a to go container with half eaten food, 1 opened nonfat milk carton dated 3/19, 4 unopened reduced fat milk cartons dated 4/16, 1 opened container of strawberry shortcake cupcakes with 2 out of 4 remaining, 1 peppermint cocoa cookie dough package unopened, and 1 opened milk drink. In the freezer, the following items were not labeled or dated: 1 large BBQ frozen drink cup that contained a brown substance overflowing and all over the cup, 1 frozen opened bacon/egg/cheese sandwich package, 1 unopened meal of chicken nuggets and macaroni/cheese. Also, 1 opened reduced fat milk carton dated 4/20 was found in the sink and was warm to the touch. Lastly, a brown substance was spilled in the freezer and throughout the refrigerator on all shelves. An observation of nourishment room #1 halls and interview were conducted with Nurse #1 on 4/18/23 at 9:40 AM. She confirmed that inside the refrigerator/freezer was "absolutely disgusting". Nurse #1 stated housekeeping performed the cleaning with the help of nursing	F 812	plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. For dietary services, corrective actions were obtained on 4/18/2023, 4/19/2023, and 4/20/2023. During initial walk through of the kitchen on 4/18/2023, it was noted dietary services had failed to prevent wet nesting of meal trays and failed to clean the convection oven for sanitary use. On 4/18/2023 trays were removed and rewashed to allow for sufficient drying prior to stacking. On 4/19/2023 dietary services deep cleaned convection oven. During observation of the nourishment rooms on 4/18/2023, 3 of the 3 nourishment room fridges/freezers were noted to have spills/food debris within the fridges. It was also noted that staff failed to properly store multiple food items or discard leftover food items. On 4/19/2023 the Dietary Service Director and Environmental Services discarded all food and drinks with expired dates or without proper labeling/dating; deep cleaning was scheduled and completed on 4/20/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 812	Continued From page 51 staff, and dietary stocked the refrigerators with snacks/supplements. b. An observation of the nourishment room in between the 100/200 halls (nourishment room #2) was conducted on 4/18/23 at 9:48 AM, and the refrigerator/freezer were inspected. The following items were found inside the refrigerator without a date or label: 1 opened salad dressing bottle, 1 opened honey mustard bottle. There were also items in the freezer without a date or label: 1 frozen chicken pot pie unopened in brown plastic bag. Also, the top 2 shelves of the refrigerator were covered with a brown liquid substance. c. An observation of the nourishment room in between the 300/400 halls (nourishment room #3) was conducted on 4/18/23 at 9:51 AM, and the refrigerator/freezer were inspected. The following items were found inside the refrigerator without a date or label: 1 bottle of pineapple mango juice unopened, 1 bottle of sports drink unopened, 2 pieces of chocolate, 1 brown cake in plastic wrap unopened, 1 coffee mug and lid with white caked substance at sipping area. In the freezer, a brown sticky substance was found on the shelf. During an interview with the Dietary Manager (DM) on 4/18/23 at 10:12 AM, he revealed dietary stocked the nourishment rooms daily with perishable/nonperishable items. Housekeeping/maintenance maintained the cleanliness and monitored temperatures of the refrigerators/freezers. The DM indicated nursing staff were supposed to label/date resident's food/drink items. During an interview with the Environmental Services Manager (ESM) on 4/18/23 at 10:24	F 812	On 4/18/2023, the Dietary Service Director completed a kitchen walk through to ensure all dishes were dried prior to storage. Cleaning for convection oven was completed on 4/19/2023. On 4/20/2023 the Administrator and Environmental Services Director visited all nourishment rooms to ensure all items in nourishment fridge and surrounding areas were labeled, dated, and stored properly. On 4/20/23 environmental services staff cleaned all nourishment fridges. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 4/19/23 by Dietary Service Director. Topics included: • Storage and dating policies and regulations. • Shift inspections to observe all food are within their dates and tossed if out of date. • Shift inspections to observe nourishment room items are with their dates and/or stored properly. • Policies and practices for nourishment room scheduled cleaning. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Dietary staff will monitor proper food	

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F 812	Continued From page 52 AM, she revealed the nourishment rooms are a group effort between nursing and housekeeping. Nursing was supposed to be cleaning after themselves and label/date food items for residents. Housekeeping was assigned to clean the room and was supposed to discard not labeled/dated/dirty items and clean the refrigerator. Nursing should have reported the cleanliness issue; however, the housekeeper should have checked the condition of the nourishment rooms daily. The interim Administrator was interviewed on 4/18/23 at 3:35 PM. He revealed that none of the items found in the refrigerators/freezers should have been there because nourishment rooms are for residents only. All items should have been labeled/dated, and the entire nourishment area, especially the refrigerators/freezers, should have been cleaned as well. The Administrator indicated all food/drink items should have been within the printed expiration date, and if any items were expired, they should have been discarded. Housekeeping should have been monitoring and cleaning the nourishment rooms daily. 2. An observation of the kitchen and interview with the DM were conducted on 4/17/23 at 10:19 AM. Seven meal trays were observed to be stacked wet and ready for use on a cart at the start of the tray line. The DM stated staff should air dry trays before meal service. An observation of the kitchen was conducted on 4/18/23 at 9:12 AM. Ten meal trays with water condensation were observed on a cart at the start of the tray line. During a follow-up interview with the DM on	F 812	storage in the nourishment room while restocking nourishment rooms on AM and PM shifts. Dietary staff will deep clean convection oven on a monthly basis or sooner depending on need. Oven cleaning schedule will be checked off as completed and reviewed by Dietary Manager. Environmental staff will monitor nourishment room cleanliness by cleaning per daily checklist. 4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe all equipment and utensils are cleaned and stored properly as well as that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. The Environmental Services Manager will check nourishment rooms daily for cleanliness and discard items in refrigerators that are expired or inappropriate (i.e not for resident use). Dietary QA Audit will be completed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality	

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F 812	Continued From page 53 4/18/23 at 10:12 AM, he revealed the meal trays were washed last night and should have been air dried before usage. During an interview with the interim Administrator on 4/18/23 at 3:42 PM, he revealed the meal trays should have been dry prior to use. 3. An observation of the kitchen and interview with the DM were conducted on 4/17/23 at 10:25 AM. The convection oven had a thick, black layer on the bottom and brown grease covered both glass doors. The DM stated he received the chemicals to clean the oven last week, and it was last cleaned 2 months ago. He further stated staff were expected to clean the oven at least monthly. An observation of the kitchen was conducted on 4/18/23 at 9:13 AM. The convection oven was in the same condition as the day prior. The interim Administrator was interviewed on 4/18/23 at 3:42 PM, he revealed the oven should have been cleaned routinely, and staff should follow the cleaning schedule for all dietary equipment.	F 812	Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the area surrounding the dumpsters free of debris for 2 of 4 dumpsters observed.	F 814	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	6/6/23

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F 814	Continued From page 54 The findings included: During an observation of the dumpster area with the dietary manager (DM) on 4/17/23 at 10:31 AM, debris was found next to and behind the back right and left dumpsters. Debris items included: pieces of paper, paper containers, soda cans, and plastic gloves. The DM stated the maintenance department maintained the dumpster area. An observation of the dumpster area was conducted on 4/18/23 at 9:24 AM revealed the dumpster area to be in the same condition. During an interview with the Environmental Services Manager on 4/20/23 at 2:31 PM, she revealed that her staff maintained the dumpster area. She stated that the dumpsters were emptied once weekly, and maintenance staff did not clean up after the garbage pickup. The Environmental Services Manager indicated that staff were expected to check the dumpster area for debris every time they take out the trash, which is 3 times daily. The interim Administrator was interviewed on 4/18/23 at 3:43 PM. He stated maintenance was responsible for the outside of the building and should have picked up the debris on a daily basis.	F 814	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. TAG 867 Dispose of Garbage and Refuse Properly 1. Immediate action(s) taken for the resident(s) found to have been affected include: No particular resident was affected by the garbage at the dumpsters. However, all residents have the potential to be affected by unsanitary conditions created by not disposing of garbage properly. The trash around the four dumpsters was picked up with a shovel or by hand on 4/18/23. Administrator inspected area on 4/19/23 and found the area around the dumpsters to be free of debris. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Maintenance director will assign an employee from her department daily to clean up trash around the dumpsters and discard in the dumpster if there is any. 3. Systemic changes. Maintenance director or administrator will inspect dumpsters daily for the month of May followed by weekly x 4 thereafter to	

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F 814	Continued From page 55	F 814	ensure area around dumpsters is clear of trash/debris. Dumpster audit sheet will be utilized. 4. Quality Assurance monitoring procedure. The Administrator will monitor this process by auditing dumpster inspection sheets weekly x 4, then monthly x 2. Results will be reported to and reviewed with QA Committee on a monthly basis. Corrective action completion date: 6/06/2023	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		6/6/23

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F 867	Continued From page 56 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F 867		

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F 867	Continued From page 57 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 58 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint survey of 02/25/22, revisit survey of 4/14/22, and complaint survey of 10/27/22. This was for 9 recited deficiencies in the areas of Quarterly Assessment At Least Every 3 Months (638), Accuracy of Assessments (641), Baseline Care Plan (655), Care Plan Timing and Revision (657), Bowel/Bladder Incontinence, Catheter, UTI (690), Label/Store Drugs & Biologicals (761), Resident Allergies, Preferences and Substitutes (806), Food Procurement, Store/Prepare/Serve - Sanitary (812), and Infection Prevention and Control (880). The continued failure during two or more federal surveys of record showed a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F638: Based on record review and staff	F 867	The statements made on this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Corrective action for resident(s) affected by the alleged deficient practice: Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 2/25/22, revisit survey of 4/14/22, and complaint survey of 10/27/22. There were for 9 deficiencies cited in the areas of Quarterly assessment	

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F 867	Continued From page 59 interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 25 residents reviewed for resident assessments (Resident #16). During the recertification and complaint survey of 02/25/22, the facility was cited for failing to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 9 of 9 residents reviewed for quarterly MDS assessments timing. (Resident #10, Resident #13, Resident #6, Resident #11, Resident #29, Resident #14, Resident #4, Resident #9, and Resident #28). F641: Based on record review and staff interview the facility failed to accurately code a diagnosis on the Minimum Data Set assessment for 1 of 1 sampled resident reviewed for Pre-admission Screening and Resident Review (Resident #16). During the recertification and complaint survey of 02/25/22, the facility was cited for failing to accurately code the ostomy status of a resident on an admission Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident #10) reviewed for activities of daily living care. F655: Based on staff interviews and record review the facility failed to develop a baseline care plan including nutrition recommendations and provide a summary of the baseline care plan to residents or their representatives for 1 of 1 resident reviewed for baseline care plans (Resident #85). During the recertification and complaint survey of 02/25/22, the facility was cited for failing to	F 867	at least every 3 months (F638), accuracy of assessments (F641), Baseline Care Plan (F655), Care Plan Timing and Revision(F657), Bowel/Bladder Incontinence, Catheter, UTI (690), Label/Store Drugs and Biologicals (761), Resident Allergies, Preferences, and Substitutes (806), Food Procurement, Store/Prepare/Serve – Sanitary (812), and Infection Prevention and Control (880). The continued failure during two or more federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: • Corrective action has been taken for the identified concerns in the areas of:Quarterly Assessment at least every 3 months (F638). • Corrective action has been taken for the identified concerns in the areas of: Accuracy of Assessments (F641). • Corrective action has been taken for the identified concerns in the areas of: Baseline Care Plan (F655). • Corrective action has been taken for the identified concerns in the areas of: Care Plan Timing and Revision (F657). • Corrective action has been taken for the identified concerns in the areas of: Bowel/Bladder Incontinence, Catheter, UTI (F690) • Corrective action has been taken for the identified concerns in the areas of:	

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F 867	Continued From page 60 develop a baseline care plan within 48 hours of admission to address the needs of the resident for 3 (Resident ' s #135, #136 & #5) of 3 residents reviewed and failed to provide a summary of the baseline care plan to the resident or responsible party for 2 (Resident ' s #135 & #136) of 3 resident ' s reviewed for baseline care plans. F657: Based on record review, resident representative interview and staff interviews, the facility failed to revise a care plan to include a physician's ordered intervention for 1 of 4 residents reviewed for dialysis (Resident #14) and to conduct a quarterly care plan meeting with the resident representative for 1 of 1 resident reviewed for care plan meetings (Resident #20). During the recertification and complaint survey of 02/25/22, the facility was cited for failing to review and revise the care plan for 2 of 4 residents reviewed for care plans (Residents #33 & #29). F690: Based on record review, staff interview, Nurse Practitioner interview, and physician interview, the facility failed to discontinue an antibiotic medication administered to treat a urinary tract infection (UTI) after the organism was identified as resistant to the medication on the laboratory report dated 02/24/23 for 1 of 3 residents reviewed for UTIs, Resident #32. During the recertification and complaint survey of 02/25/22, the facility was cited for failing to prevent a urinary catheter bag from encountering the floor to reduce the risk of infection or injury. This occurred for 1 of 1 resident (Resident #77) reviewed for urinary catheter. F761: Based on observation and staff interviews	F 867	Label/Store Drugs and Biologics (F761). • Corrective action has been taken for the identified concerns in the areas of: Resident Allergies, Preferences, and Substitutes (F806). • Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Store/Prepare/Serve-Sanitary (F812), and • Corrective action has been taken for the identified concerns in the areas of: Infection Prevention and Control (F880). The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 05/12/2023 to review the deficiencies from the April 17-20 annual recertification survey, CI survey, and reviewed the citations. On 05/12/2023, the Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 5/12/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the	

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F 867	Continued From page 61 the facility failed to record an opened date on 3 of 4 insulin pens and failed to discard 1 of 1 expired insulin pens on 1 of 2 medication carts (700 Hall) observed for medication storage, failed to discard a tablet laying in the 100 hallway and left medications at the bedside for 2 of 2 residents who had not been assessed for safety of self-medication (Resident #33 and Resident #63). During the complaint survey of 10/27/22, the facility was cited for failing to keep unattended medications stored in a locked medication cart for 1 of 2 medications carts observed (400-Hall medication cart). F806: Based on observations, record review, resident and staff interviews, the facility failed to honor food preferences for 1 of 4 residents reviewed for food preferences (Resident #48). During the recertification and complaint survey of 02/25/22, the facility was cited for failing to obtain food preferences for residents including newly admitted residents and failed to provide preferred food selections for residents when selected menus were not incorporated into the meal tray slip system. This was for 4 of 4 residents reviewed for complaints about food preferences (Residents #65, #136, #47, #17). F812: Based on observation and staff interviews, the facility failed to 1) label and date leftover food/drink items and clean the refrigerators/freezers in three of three nourishment rooms (nourishment room #1, #2 and #3) 2) allow meal trays to air dry prior to assemblage and stacking for two of two observations 3) clean the convection oven. These practices had the potential to affect all residents.	F 867	committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 6/6/2023	

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F 867	Continued From page 62 During the recertification and complaint survey of 02/25/22, the facility was cited for failing to label opened food items stored in refrigerators with an open date or a sue by date for 1 of 1 walk in cooler and 1 of 2 nourishment room refrigerators. The facility also failed to maintain the refrigerator in the 400 hall nourishment room free from dried food buildup and dried spills for 1 of 2 nourishment room refrigerators. This practice had the potential to affect food served to residents. During the revisit survey of 04/14/22, the facility failed to discard food and beverage items stored ready for use past the expiration and/or use by dates in 2 of 2 refrigerators observed in the kitchen. This practice had the potential to affect food served to residents. F880: Based on record review and staff interviews, the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 97 of 97 residents in the facility. During the recertification and complaint survey of 02/25/22, the facility was cited for failing to 1) follow facility policy when collecting COVID-19 nasopharyngeal specimens while within six feet of residents when Phlebotomist #1 performed nasopharyngeal COVID-19 testing for 2 of 2 residents (Residents #335 and #535) and 2) failed to use a N95 mask when NA #3 entered a COVID-19 positive resident ' s room (Resident #336) to obtain a blood pressure reading for 1 of 1 resident.	F 867		

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F 867	Continued From page 63 In an interview with the facility Interim Administrator on 04/20/23 at 5:06 PM, he stated he had only been at the facility for 4 days and had no idea why the Quality Assurance program did not work. He noted the Quality Assurance book that was in the office when he arrived had no plans for improvement in it and left him with no information.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		6/6/23

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F 880	Continued From page 64 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 880	The statements made on this plan of	

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F 880	Continued From page 65 facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 97 of 97 residents in the facility. Findings Included: The facility's "Infection Prevention and Control Program" policy dated 1/2023 stated the Infection Preventionist (IP) was responsible for completing surveillance of healthcare associated infections, tracking outbreaks and monitoring standard and transmission precautions. During a meeting with the Infection Preventionist (IP) on 4/20/2023 at 3:45 p.m. the IP was unable to provide any documentation of tracking or surveillance of infections, infection risks or communicable disease outbreaks. A handwritten Facility's Long-Term Care (LTC) Respiratory Surveillance Line list dated 2/5/2023 was provided by the facility on 4/20/2023 at 5:30 p.m. listed six residents and three staff members that had tested positive for COVID-19. The Surveillance COVID listing did not list the onset of symptoms for 6 of 9 residents, COVID testing information for 3 of 9 listed, COVID testing results for 6 of 9 listed and the date of resolution of symptoms for 9 of 9 listed on the form. On 4/20/2023 at 3:45 p.m. in an interview with the Infection Preventionist, she stated the last positive case of COVID-19 was in March 2023. She explained she only notified the Director of Nursing and the Administrator when residents and staff tested positive for COVID, and she was not collecting surveillance data for COVID infections in the facility. When asked about the	F 880	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 The facility failed to implement an infection surveillance plan for monitoring and tracking of infections in the facility. 1. How corrective action will be accomplished for those residents found to have been by the deficient practice: On 5/3/2023 the Director of Nurses educated the Infection Control Preventionist on the facility Infection Prevention and Control Policy and the expectation of the completion of ongoing surveillance for healthcare associated infections, the tracking of outbreaks and monitoring of standard and transmission-based precautions. On 5/12/2023 the Infection Control Preventionist completed the line listing for the six residents and three staff who had tested positive for Covid 19. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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	345519	A. BUILDING _____ B. WING _____	C 04/21/2023

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F 880	Continued From page 66 collection of data to surveillance infections like urinary tract infections, pneumonia, residents on transmission-based precautions, the IP stated in daily morning meetings residents' laboratory tests were reviewed to ensure residents were on antibiotics as needed but she was not collecting surveillance data for those infections. When asked how she was collecting data on infections in the facility to provide an infection control report to the Quality Assurance and Performance Improvement (QAPI) meetings, she stated she had not been tracking infections in the facility and collecting surveillance data, therefore, she was not able to report surveillance data to QAPI. In a follow up phone interview on 4/21/2023 at 1:51 p.m., she stated she was hired as a as needed (prn) status Staff Development Coordinator (SDC) and only learned the first of April 2023 she was also the acting Infection Preventionist. She stated she had received no training in the role of Infection Preventionist, and she didn't know the collection of surveillance data for infections was expected of her in the role as the Infection Preventionist. On 4/20/2023 at 4:37 p.m. in an interview with the Director of Nursing (DON), she explained a previous Administrator hired the IP to work as needed as the SDC and IP. She stated the Infection Preventionist had been working Monday through Friday, and the IP was responsible for the infection control program that included the collection of surveillance data of any infections in the facility. The DON stated since she had received the Statewide Program for Infection Control and Epidemiology (SPICE) training, she served as resource person for infection control issues in the absence of the IP.	F 880	On 5/11/2023 the Infection Control Preventionist reviewed all infection control data for the month of April to assure that surveillance of healthcare associated infections and tracking of outbreaks were in place. This was completed through review of physician orders for antibiotic utilization for April 2023 and review of healthcare associated infections for the months of April 2023. Review for any infection control trends was completed also for April 2023. Starting on 5/20/2023 random observation of 5 staff/agency was done by the Infection Control Preventionist to assure standard and transmission-based precautions were in place with no concerns identified. All infection control data was compiled into a monthly infection control report and presented by the Infection Control Preventionist to the monthly Quality Assurance and Improvement Committee on 5/12/2023. The Quality Assurance Committee includes the Administrator, Director of Nurses, Medical Director, Infection Control Preventionist, Therapy Manager, Dietary Manager, Health Information Manager and the Minimum Data Set Nurse. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: On 5/20/2023 the Nurse Consultant began education of the Director of	

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F 880	Continued From page 67 On 4/20/2023 at 5:30 p.m. in an interview with the Administrator, he explained how the facility had experienced a mass turnover the last couple of months in the Administration team, and he had only been at the facility for one week. He stated the IP, who started in January 2023, was working as needed in the SDC and IP role until the facility could hire a full time SDC/IP person. He stated there were no infection control reports when reviewing past QAPI meeting notes and stated the collection of surveillance data for infections in the facility had not been conducted accurately, if performed at all. He shared he thought facilities didn't have to complete the COVID Surveillance Line listing anymore.	F 880	Nurses/Infection Control Preventionist/Licensed Nursing Home Administrator and the Quality Assurance and Improvement Committee on the facility Infection Prevention and Control Policy and the expectation of the completion of surveillance for healthcare associated infections, the tracking of outbreaks and monitoring of standard and transmission-based precautions per the facility infection control and prevention policy. In addition the DON/ICP will observe 3 random staff/agency on various days of the week and shifts to assure principles of standard and transmission based precautions are in compliance This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Education will be completed by 6/05/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Administrator will audit compliance with the F880 Infection Surveillance and Tracking/Monitoring Process to assure compliance with the facility Infection Prevention and Control Program. Monitoring to be done weekly x 4 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective	

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F 880	Continued From page 68	F 880	action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing/Infection Control Preventionist, Minimum Data Set Coordinator, Therapy, Health Information Manager and Dietary Manager and the Medical Director. Date of Compliance: 6/ 6/2023	