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	345078	A. BUILDING _____ B. WING _____	C 04/27/2023

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 04/24/23 through 04/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7SDG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 04/24/23 through 04/27/23. Event ID# 7SDG11. The following intake was investigated NC00195195. Two of the five complaint allegations resulted in deficiency.	F 000		
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the	F 626		5/19/23

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

Electronically Signed | 05/17/2023

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F 626	Continued From page 1 requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director, Responsible Party, and staff the facility failed to allow a resident who experienced delusions and exit seeking behaviors to return to the facility following a hospital admission using the resident's behaviors prior to transfer as a basis for their decision for 1 of 1 resident reviewed for hospitalization (Resident #252). Resident #252 remained in the hospital from 08/30/22 through 11/09/22 waiting for placement to another facility. The findings included: Resident # 252 was admitted to the facility 08/02/22 with diagnoses including Parkinson's disease and dementia. Review of the care plan started on 08/05/22 identified Resident #252 as having impaired decision making related to his dementia that included behaviors and being at risk for elopement. Interventions included: to provide a consistent physical environment and daily routine;	F 626	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. Resident 252 currently does not reside at the facility to correct the deficient practice. The facility recognizes that all residents that transfer out to the hospital have the potential to be affected by this practice. An audit was conducted by the Health Services Director on May 15, 2023 of all residents transferred to the hospital in the last 30 days to ensure that they met the criteria for appropriate return to the facility. Only one transfer to the hospital was noted during this audit and the resident	

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F 626	Continued From page 2 determine where the resident was going and validate his need to find someone or something; provide close monitoring when restless and wandering; redirect from other resident rooms, unsafe areas, and exits; and apply a wander guard device. Review of the admission Minimum Data Set (MDS) dated 08/06/22 revealed Resident #252 was assessed as having moderately impaired cognition. The MDS indicated Resident #252 experienced hallucinations and wandering behaviors that occurred 1 to 3 days during the lookback period. Review of the most recent Medical Director (MD) note revealed on 08/12/22 Resident #252 was evaluated for management of Parkinson's disease and hypertension. The MD's note indicated Resident #252 was admitted to the facility due to increased falls and confusion while at home and was admitted to the facility for further care. The MD noted Resident #252 has had episodes of confusion and remained on divalproex (an anticonvulsant medication used for the treatment of mania) and requested a psychiatric consultant. Review of a psychotherapy progress note dated 08/19/22 revealed Resident #252 was evaluated to address increased compliance with his treatment plan, reduction in assaultive or inappropriate behaviors, and stabilization of a depressed mood. The note included the facility staff's description of behaviors were agitation that was spontaneous and aggressive behavior triggers varied and the presence of depression. Resident #252's appearance/behaviors described during the evaluation were the presence of	F 626	did not return due to expiring at the hospital and no behaviors had happened prior to transfer. The audit revealed no other concerns. The Clinical Staff Educator will educate the Health Services Director, Director of Nursing and the Social Worker/Admissions on the facility Bed Hold Policy - permitting residents to return to the facility following a hospital admission if their needs can be met. This education will be completed by May 19, 2023. The facility will only utilize current hospital documentation when determining if a resident is clinically appropriate to return to the facility. The Admission Coordinator/designee will submit all hospital documentation to the Interdisciplinary Team for review to determine if the facility is able to meet the needs of the resident. Documents regarding the denial decision will be uploaded into the residents Electronic Medical Record with the IDT and Medical Director signatures stating the denial reason. The Health Services Director will conduct audits of all hospital transfers and readmissions to ensure they meet all the requirements of the Bed Hold policy □ permitting residents to return to the facility following a hospital admission if their needs can be met. This will occur weekly for 4 weeks and then monthly for 1 month.	

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tremors, being cooperative with poor insight and anxious. The psychotherapist treatment plan was to continue individual psychotherapy 1 to 4 times a month to help maintain the current level of independence.

Review of a psychotherapy progress noted dated 08/22/22 revealed during the evaluation Resident #252 was described as less agitated, calmer but confused. The note indicated he was actively engaged and cognitively capable of benefiting towards the goals of his treatment and the psychotherapist wanted to continue with the current plan.

Review of a progress written on 08/24/22 at 4:48 PM by Nurse #2 revealed Resident #252 was outside in the courtyard shaking the gate in attempt to force it open. He had also indicated a thief had come in his room and taken the bedrails off the bed. The on-call provider was contacted and provided an order to administer 1 milligram of alprazolam (an antianxiety medication) now for agitation. Resident #252's emergency contact was called to help intervene and a nurse staff member was able to talk to Resident #252 and get him to leave the gate and come inside and return to his room. Resident #252 took his prescribed medications, including the alprazolam.

Review of the progress note written on 08/25/22 at 2:31 PM by Nurse #2 revealed Resident #252 exited his room wearing only pants and tried to force his way into another resident's room. Staff were able to prevent his entry. Resident #252 then tried to push on a back door and was redirected towards his room. He also tried to push a laundry cart over onto an employee and continued to push on exit doors. Attempts to

Variances will be corrected at the time of discovery and additional education/corrective action provided as needed.

Audit results will be reported for two months by the Health Services Director to the Quality Assurance Performance and Improvement committee to identify trends and further opportunities for improvement.

Completion date of May 19, 2023

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redirect failed and he entered the courtyard where he ran and tried to jump over and climb the fence. Nurse #2 obtained a physician order and administered an intramuscular injection of haloperidol (an antipsychotic medication) 1 milligram and Resident #252 was placed in bed.

Review of the progress note written on 08/25/22 at 3:31 PM by the Social Worker (SW) revealed Resident #252 was experiencing a severe delusion and believed he was under siege and observed holding a handful of flowers he believed to be a hand grenade. He repeatedly kicked a door to the outside and stated, "they are everywhere, nowhere is safe, and we have to get out of here." The note indicated the SW reduced the noise level and calmly repeated they were safe and was able to calm Resident #252 until he became catatonic with his eyes open and fixed and in a frozen physical position. Emergency Medical Service (EMS) was called and transported Resident #252 to the emergency department. The SW note indicated she was concerned for Resident #252's safety and the safety of other residents and staff.

Review of the discharge MDS dated 08/25/22 revealed Resident #252 had an unplanned discharge to the hospital and was expected to return to the facility.

Review of the facility-initiated notice of transfer/discharge revealed the date the notice was given to the Responsible Party was on 08/25/22 and the date the facility expected Resident #252 to transfer/discharge from the facility was by 09/23/22. The reasons Resident #252 was being transferred/discharged were listed as follows: it was necessary for the welfare

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F 626	Continued From page 5	F 626		

and needs that could not be met in the facility; the safety of individuals in the facility were endangered due to clinical or the behavioral status; and the health of individuals in the facility would otherwise be endangered. The notice indicated the facility planned to transfer/discharge Resident #252 home with caregivers or to a special care unit with skilled nursing services. The notice was signed by the Administrator on 08/25/22.

Review of the EMS report dated 08/29/22 revealed Resident #252 was transferred from the facility on 08/25/22 to the geriatric psychiatric unit of the hospital. The psychiatric unit called EMS on 08/29/22 requesting Resident #252 be transported to the emergency department of the hospital for review of unusual cycling behavior from being combative to unresponsive and back again. The EMS report described Resident #252's behavior during their assessment was combative with accurate fist swings that appear to be aimed at providers. Gentle restraint was used to prevent Resident #252 from harming himself or providers and he returned to having a decrease in his level of consciousness and was transported to the emergency department at the hospital.

Review of the first hospital referral sent to the facility dated 08/30/22 revealed the facility declined to allow Resident #252 to return. The reasons the facility provided indicated the care needs exceeded current staffing capability and behavioral issues.

Review of the facility census dated 08/30/22 revealed the facility had beds available to readmit Resident #252.

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A second hospital referral was sent to the facility on 09/09/22. The facility's response dated 09/12/22 indicated there was no bed available and the facility had no contract with Resident #252's insurance carrier and declined to allow him to return.

A third hospital referral was sent to the facility on 09/19/22. On 09/20/22 the facility's response indicated there was no bed available, care needs exceeded current staffing capabilities, behavioral issues, and declined to allow Resident #252 to return.

A fourth hospital referral was sent to the facility on 10/19/22. The facility's response indicated they were unable to meet the needs of Resident #252 and declined to allow him to return.

Review of the hospital discharge summary dated 11/09/22 revealed Resident #252 was admitted on 08/29/22 for episodes of syncope (a loss of consciousness commonly known as fainting). The summary indicated he was transferred from the facility on 08/25/22 and admitted to hospital's geriatric psychiatric unit. On 08/29/22 he was transferred from the geriatric psychiatric unit to the hospital's emergency department for evaluation of syncope episodes and cardiac monitoring and was admitted. The summary indicated the family elected for comfort care measure and Resident #252 remained at the hospital waiting for placement at a skilled nursing facility or inpatient hospice. The summary also indicated placement had been challenging given funding and prior behaviors. Placement was found at a another skilled nursing facility that provided the same nursing services as the facility he was discharged from. Resident #252 was not

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admitted to a locked unit at the new skilled nursing facility. He was discharged from the hospital on 11/09/22 in stable condition to the new skilled nursing facility. His discharge diagnoses included syncope with no recurrence, mild acute kidney failure that was resolved, Parkinson's disease that was stable, and dementia with behavioral disturbances.

An interview on 04/25/23 at 3:17 PM was conducted with the Responsible Party (RP) of Resident #252. The RP revealed the facility declined to allow Resident #252 to return after being discharged to the hospital. The RP revealed the reason he was given was because the facility couldn't handle Resident #252's behavior episodes and attempts to elope from the facility. The RP stated the Administrator and facility's Interdisciplinary Team were adamant about not letting the resident return and didn't help locate another facility after discharge and he was told Resident #252 was not coming back to the facility.

An interview was conducted on 04/26/23 at 1:38 PM with the second listed Emergency Contact for Resident #252. The Emergency Contact revealed she worked at the facility when Resident #252 was admitted until his discharge and her title was the Director of Nursing (DON). The Emergency Contact/DON revealed she was aware of the facility's transfer/discharge policy and explained if the resident's needs could be met the facility was required to allow Resident #252 to return. The Emergency Contact/DON revealed she received the transfer/discharge notice from the SW after Resident #252 was transferred to the hospital. She revealed when the hospital sent the referral to the facility, she reviewed the history and

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physical and did not find any changes that would prevent the facility from readmitting Resident #252 and shared with the Administrator there were no behaviors on the hospital report.

An interview was conducted on 04/26/23 at 11:03 AM with Social Worker (SW). The SW confirmed the DON at that time was also listed as Resident #252's second Emergency Contact. The SW stated the facility could not manage Resident #252's care due to his psychotic behaviors. The SW revealed after Resident #252 was discharged from the facility it was not her role to make the decision if he could return or not.

During an interview on 04/26/23 at 12:25 PM the Administrator revealed the facility declined the hospital referrals for Resident #252 to be readmitted and she was aware his Emergency Contact/DON wanted him to return to the facility. The Administrator described Resident #252's behaviors prior to his discharge from the facility as trying to climb over fences in the courtyard and rip open the gate; running down the hallways full speed and almost impossible to stop and bring him back to reality. The Administrator revealed the decision not to allow Resident #252 to return were based on those behaviors of exit seeking, difficultly to redirect, the fact the facility did not have a locked unit or enough staff to provide the 1 on 1 supervision he needed and decided it was not safe for Resident #252, the staff, or other residents for him to return to the facility.

During an interview on 04/27/23 at 11:09 AM the Medical Director (MD) described Resident #252 as having a lot of confusion that included being agitated with combative behaviors and wanting to leave the facility. The MD stated Resident #252

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F 626	Continued From page 9 was an elopement risk and more appropriate for a locked unit. The MD revealed he was not included in the decision not to allow Resident #252 to return to the facility.	F 626		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		5/19/23

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F 636	Continued From page 10 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete care area assessments to address underlying causes and contributing factors for the triggered areas for 1 of 5 residents reviewed for unnecessary medication. (Residents #33). The findings included: Resident #33 was admitted to the facility on 02/09/21.	F 636	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. Resident 33□s comprehensive	

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F 636	Continued From page 11 Review of Section V (Care Area Assessment Summary) for the significant change in status Minimum Data Set (MDS) dated 12/08/22 revealed 8 care areas had been triggered. Five of the care area assessments (CAAs) triggered did not contain any analysis addressing the nature of Resident #33's condition, the presence of causes and contributing factors, risk factors related to the care area, and the reasons for a decision to proceed with care planning. The incomplete CAAs consisted of psychotropic drug use, activities of daily livings functional and rehabilitation potential, urinary incontinence and indwelling catheter, falls, and pressure ulcer/injury. The most recent quarterly MDS dated 03/10/23 assessed Resident #33 with severe impaired cognition, minimal hearing difficulty, and impaired vision. He received insulin daily and antidepressant 6 days during the 7-day assessment periods. During an interview conducted on 04/25/23 at 1:32 PM, the MDS Coordinator explained she worked as the MDS Coordinator since 01/18/23. The former MDS Coordinator would have been responsible for completing the CAA summaries for Resident #33. She acknowledged that the CAAs, especially the analysis of findings was incomplete without description of the problems, causes and contributing factors, risk factors, and reasons to proceed with care planning. During an interview conducted on 04/26/23 at 3:30 PM, the Resident Care Coordinator stated he started to review the MDS Coordinator's work and signed off the completed MDS before	F 636	assessment will be modified to include the appropriate CAA information by May 19, 2023. The MDS Coordinator will review December 2022 and January 2023 comprehensive assessments for accuracy in the CAA section. Inaccuracies of the CAA analysis will be modified if needed. Education on F636 - Resident Assessment 483.20 will be provided by the MDS Coordinator to the Interdisciplinary team members and any new hires going forward so that they understand how to complete the CAA analysis section of the MDS. This will be completed by May 19, 2023. The Comprehensive Assessments will be reviewed weekly during Standards of Care to ensure that the CAA analysis section are accurate and completed prior to submission. The MDS coordinator will audit all comprehensive assessments for one month and then 5 assessments for one month to ensure proper documentation for the CAA section including the underlying causes and contributing factors for the triggered CAA areas. Variances will be corrected at the time of discovery and additional education/corrective action provided as needed. Audit results will be reported for two months by the MDS coordinator to the Quality Assurance Performance and	

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F 636	Continued From page 12 submission since mid-January 2023. He clarified that the former MDS Coordinator had signed and submitted Section V for the MDS dated 12/08/22. He acknowledged that the analysis of findings was incomplete. He stated it should have contained at least a description of the problems, causes and contributing factors, risk factors, and reasons to proceed with care planning. He added he would complete and re-submit the MDS as soon as possible. Attempt to interview the former MDS Coordinator on 04/27/23 at 2:37 PM was unsuccessful. She was not available and did not return the call. On 04/27/23 at 3:28 PM, a joint interview was conducted with the Director of Nursing and the Administrator. Both stated all the CAAs must be individualized. It was their expectation for the MDS Coordinator to complete all the CAAs comprehensively before submission.	F 636	Improvement committee to identify trends and further opportunities for improvement. Date of Completion is May 19, 2023	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		5/23/23

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F 640	Continued From page 13 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to complete and transmit the discharge Minimum Data Set (MDS) within 14 days of the discharge date for 2 of 3 residents	F 640	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is	

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F 640	Continued From page 14 reviewed for resident assessments (Resident #61 and #341). The findings included: 1. Resident #61 was admitted to the facility on 11/23/22. Review of Resident #61's medical record revealed the last completed Minimum Data Set (MDS) assessment was an admission MDS dated 11/27/22. There was no discharge assessment completed. Review of a nurse progress note revealed on 12/09/22 Resident #61 was discharged to his home. During an interview on 04/25/23 at 2:06 PM the MDS Coordinator revealed she was new to her position as of January 2023. She explained the facility recognized resident assessments were not being completed or scheduled in accordance with the regulations. The MDS Coordinator stated she would complete the discharge MDS assessment for Resident #61. During an interview on 04/27/23 at 4:55 PM the Administrator explained the MDS Coordinator did not identify the missing discharge MDS assessment for Resident #61. The Administrator explained the facility currently has a fulltime MDS Coordinator and no longer used a remote MDS Coordinator and she expected resident assessments to be completed and transmitted in accordance with the regulations. 2. Resident #341 was admitted to the facility on 12/12/22.	F 640	not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. Resident 61 and Resident 341 had their discharge assessment completed and transmitted on April 26, 2023. The MDS Coordinator ran the Missing OBRA Assessment Casper Report on April 26, 2023 and no additional missed assessments were found. Education on F640 □ Encoding/Transmitting Resident Assessments will be provided by the MDS coordinator/Staff Development Coordinator to any new hire MDS coordinators in the future. The current MDS coordinator will be educated by the Director of Nursing on Encoding/Transmitting Resident Assessments by May 22, 2023. Missing OBRA Assessment Casper Report will be run weekly to ensure that discharge assessments are completed and transmitted timely. The MDS coordinator will audit the missing OBRA Assessment Casper Report weekly x4 and then monthly x2. Variances will be corrected at the time of discovery and additional education/corrective action provided as needed. Audit results will be reported for three months by the MDS Coordinator to the	

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F 640	Continued From page 15 Review of Resident #341's medical record revealed the last completed Minimum Data Set (MDS) assessment was an admission MDS dated 12/18/22. There was no discharge assessment completed. Review of a nurse progress note dated 01/10/23 indicated Resident #341 was discharged to her home on 01/09/23. During an interview on 04/25/23 at 2:06 PM the MDS Coordinator revealed she was new to her position as of January 2023. She explained the facility recognized resident assessments were not being completed or scheduled in accordance with the regulations. The MDS Coordinator stated she would complete the discharge MDS assessment for Resident #341. During an interview on 04/27/23 at 4:55 PM the Administrator explained the MDS Coordinator did not identify the missing discharge MDS assessment for Resident #341. The Administrator explained the facility currently has a fulltime MDS Coordinator and no longer used a remote MDS Coordinator and she expected resident assessments to be completed and transmitted in accordance with the regulations.	F 640	Quality Assurance Performance and Improvement committee to identify trends and further opportunities for improvement. Completion date will be May 23, 2023	
F 756 SS=D	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	F 756		5/19/23

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F 756	Continued From page 16 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. §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 and interviews with the resident, staff, Consultant Pharmacist, Nurse Practitioner (NP), and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 residents reviewed for unnecessary	F 756	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of	

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F 756	Continued From page 17 medications (Residents #7). The findings included: Resident #7 was admitted to the facility on 08/01/19 with diagnoses included hyperlipidemia. Review of physician's orders dated 03/07/20 revealed Resident #7 had an order to receive 1 tablet of atorvastatin 20 milligrams (mg) once daily for hyperlipidemia since its initiation. Review of Resident #7's medical records revealed her last lipid panel was completed on 09/08/20. No subsequent lipid panel had been documented since then. The quarterly Minimum Data Set (MDS) dated 04/03/23 assessed Resident #7 with moderate impaired cognition. A review of medication administration records (MARs) on 04/24/23 indicated Resident #7 had received atorvastatin 20 mg once daily at bedtime as ordered since its initiation on 03/07/20. Review of Resident #7's medical records on 04/26/23 revealed the Consultant Pharmacist had conducted medication regimen reviews (MRRs) monthly the past 12 months. No recommendations related to cholesterol monitoring or lipid panel had been made to the physician. During an interview conducted on 04/26/23 at 12:14 PM, Nurse #1 confirmed Resident #7 had received atorvastatin daily for the past 12 months. She measured Resident #7's vital signs on regular basis and indicated they were within the	F 756	Correction is submitted to meet requirements established by Federal and State Law. The Lipid panel was ordered for resident #7 and completed on May 10, 2023. The Consultant pharmacist audited current residents on May 16, 2023 and recommended appropriate labs for any residents on cholesterol medications and these were sent to the medical providers for review. The Consultant pharmacist was educated on May 10, 2023 by the Director of Nursing and any future Consultant Pharmacists will be educated on the regulation related to F756 Drug Regimen Review to identify all drug irregularities during MRRs and provide recommendations to the provider according to the published lipid guidelines to ensure all the required labs were completed in timely manner. The Resident Care Coordinator was educated by the Director of Nursing on auditing for residents on cholesterol medications to ensure lipid panels are being recommended by the Consultant Pharmacist. The Consultant pharmacist will recommend routine yearly lipid panel on all residents on cholesterol medications per regulation. After the Consultant Pharmacist completes monthly Medication Regimen	

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F 756	Continued From page 18 normal limits. An interview was conducted with the Medical Record Coordinator on 04/26/23 at 12:28 PM. She confirmed the last lipid panel for Resident #7 was completed on 09/08/20. She could not find any lipid panels documented for Resident #7 after 2020. During an interview conducted on 04/26/23 at 12:40 PM, Resident #7 could not recall any lipid panels being completed in the past year but stated she had been taking cholesterol lowering medication daily the past few years. A phone interview was conducted with the NP on 04/26/23 at 12:57 PM. She stated it would be clinically beneficial for Resident #7 to have a lipid panel as it had not been done since 2020. She had not noticed the lipid panel was not being completed for Resident #7 for more than 1 year and she expected the CP to alert her. A phone interview was conducted with the NP on 04/26/23 at 12:57 PM. She stated it would be clinically beneficial for Resident #7 to have a lipid panel as it had not been done since 2020. She did not notice a lipid panel had not being completed for Resident #7 more than a year. During a phone interview conducted on 04/26/23 at 1:04 PM, the MD expected the facility to conduct a lipid panel for Resident #7 at least once per year according to the published lipid guidelines. It was his expectation for the CP to recommend the lipid panel when it had not been in place for more than 1 year. During a phone interview conducted with the	F 756	Reviews, the Resident Care Coordinator will audit current residents on cholesterol medications to ensure a lipid panel is recommended within the recommended guidelines for three months. Variances will be corrected at the time of discovery and additional education and/or corrective action with be provided as needed. Audit results will be reported for three months by the Resident Care Coordinator to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Completion date will be May 19, 2023	

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F 756	Continued From page 19 Consultant Pharmacist on 04/26/23 at 3:07 PM, he acknowledged that he had performed MRR monthly for Resident #7 the past few years. He did not notice Resident #7's lipid panel was not in place since 09/08/20. He stated Resident #7 was diagnosed with hyperlipidemia. She needed to have lipid panel completed at least once every year. During a joint interview with the Director of Nursing and the Administrator on 04/27/23 at 3:28 PM, both expected the Consultant Pharmacist to identify all drug irregularities during MRRs and provided recommendations to the provider according to the published lipid guidelines to ensure all the required labs were completed in timely manner.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. 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	F 757		5/19/23

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F 757	Continued From page 20 §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 and interviews with the resident, staff, Consultant Pharmacist, Nurse Practitioner (NP), and Medical Director (MD), the facility failed to monitor the cholesterol level for 1 of 5 residents reviewed for unnecessary medications (Residents #7). The findings included: Resident #7 was admitted to the facility on 08/01/19 with diagnoses included hyperlipidemia. Review of physician's orders dated 03/07/20 revealed Resident #7 had an order to receive 1 tablet of atorvastatin 20 milligrams (mg) once daily for hyperlipidemia since its initiation on 03/07/20. Review of Resident #7's medical records revealed her last lipid panel was completed on 09/08/20. No subsequent lipid panel had been documented since then. The quarterly Minimum Data Set (MDS) dated 04/03/23 assessed Resident #7 with moderately impaired cognition. A review of medication administration records (MARs) on 04/24/23 indicated Resident #7 had received atorvastatin 20 mg once daily at bedtime as ordered since its initiation. During an interview conducted on 04/26/23 at	F 757	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. A Lipid panel was ordered for resident #7 and completed on May 1, 2023. The Consultant pharmacist completed an audit on May 16, 2023 and made recommendations for appropriate labs for any residents on cholesterol medications and sent to the medical providers for review. Education was provided to the Medical Director, Nurse Practitioner, Resident Care Coordinator by the Director of Nursing and will be provided to any new hires going forward on F757 □ the Residents Drug Regimen is free from Unnecessary Drugs. This Education was completed on May 19, 2023. Resident Care Coordinator will audit new admissions and readmissions for any residents on cholesterol medications to ensure a lipid panel has been ordered and	

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F 757	Continued From page 21 12:14 PM, Nurse #1 confirmed Resident #7 had received atorvastatin daily the past 12 months. She measured Resident #7's vital signs on regular basis and indicated they were within the normal limits. An interview was conducted with the Medical Record Coordinator on 04/26/23 at 12:28 PM. She confirmed the last lipid panel for Resident #7 was completed on 09/08/20. She could not find any lipid panels documented for Resident #7 after 2020. During an interview conducted on 04/26/23 at 12:40 PM, Resident #7 could not recall any lipid panels being completed in the past year but stated she had been taking cholesterol lowering medication daily the past few years. A phone interview was conducted with the NP on 04/26/23 at 12:57 PM. She stated it would be clinically beneficial for Resident #7 to have a lipid panel as it had not been done since 2020. She did not notice a lipid panel had not being completed for Resident #7 more than a year. During a phone interview conducted on 04/26/23 at 1:04 PM, the MD expected the facility to complete a lipid panel for Resident #7 at least once per year according to the published lipid guidelines. During a phone interview conducted with the Consultant Pharmacist on 04/26/23 at 3:07 PM, he acknowledged that he had performed medication regimen review (MRR) monthly for Resident #7 in the past few years. He did not notice Resident #7's lipid panel was not in place since 09/08/20. He stated Resident #7 was	F 757	completed per the recommended guidelines. This will occur weekly x4 and then monthly x2. Audit Results will be reported by the Resident Care Coordinator for three months to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for improvement. Completion date will be May 19, 2023	

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F 757	Continued From page 22 diagnosed with hyperlipidemia. She needed to have lipid panel completed at least once every year. During a joint interview with the Director of Nursing and the Administrator on 04/27/23 at 3:28 PM, both expected the Consultant Pharmacist to identify all drug irregularities during MRRs and provided recommendations to the provider according to the published lipid guidelines to ensure all the required labs were completed in timely manner.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food from 1 of 1	F 812	This Plan of Correction constitutes the facilities written allegation of compliance	5/24/23

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F 812	Continued From page 23 dry food storage rooms and from 1 of 4 kitchen refrigerators (lift top refrigerator). This practice had the potential to affect food served to residents. Findings included. A. On 4/24/23 at 8:49 AM an observation of the dry goods storage room in the kitchen with the Dietary Manager (DM) revealed one opened package of pancake mix with the date 3/12 use by 4/12 written on it. The DM immediately removed the package of pancake mix and stated that a kitchen staff was assigned to check the dry storage food area for expired food 5 days every week in the evenings. The DM said pancake mix was overlooked when the dry goods storage room was checked the previous Friday. B. On 4/24/23 at 9:17 AM an observation of a reach-in flip top refrigerator found an opened 1-gallon milk container, with an expiration date of 4/17/23 printed on the container. The DM immediately removed the milk container. He stated all refrigerators in the kitchen are checked nightly for any expired food items and disposed of. The expired milk was overlooked by the assigned staff the previous night. The Administrator stated on 4/27/23 at 4:04 PM that all food items in the kitchen should be checked for expiration dates and expired food products should be disposed.	F 812	for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. The expired milk and pancake mix was discarded upon discovery. The facility recognizes that all residents have the potential to be affected. The cooler and dry storage area was audited on April 24, 2023 by the Dietary Supervisor for any other items that could be expired and it revealed no additional concerns. The Dietary Supervisor/designee will educate current dietary team members and any new hires on dating/labeling and removing expired food from the refrigerator/dry storage area per facility policy. This education will be completed by May 24, 2023. Any dietary team member that has not completed the education by May 24, 2023 will be unable to work until the education is complete. The Dietary Supervisor/designee will conduct audits of food items in the refrigerator and dry storage area 5X/week for 2 weeks, 2X/week for 2 weeks, weekly for 2 weeks and then monthly for 1 month to ensure that all items are dated, labeled/stored and expired items removed per facility policy. Variances will be	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24	F 812	corrected at the time of discovery and additional education/corrective action provided as needed. Audit results will be reported for three months to the Quality Assurance Performance and Improvement committee by the Dietary Supervisor to identify trends and further opportunities for improvement. Date of Completion 5/24/23	
F 867 SS=D	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 §483.70(e) and including how such information will be used to develop and monitor performance	F 867		5/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345078	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 867	Continued From page 25	F 867		

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.

§483.75(e) Program activities.

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F 867	Continued From page 26 §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 activities, including implementation of the QAPI program required under paragraphs (a) through	F 867		

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F 867	Continued From page 27 (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 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the annual recertification survey conducted on 07/28/21. This was for one deficiency originally cited in July 2021 in the area of Drug Regimen is Free from Unnecessary Drugs and was subsequently recited on the current annual recertification survey of 04/27/23. The duplicate citation during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to: During the annual recertification survey conducted on 04/27/23, the facility failed to monitor the cholesterol level for 1 of 5 residents reviewed for unnecessary medications (Residents #7). F757: During the annual recertification survey conducted on 07/28/21, the facility failed to follow the parameter set by the physician to hold the diuretic as ordered for 1 of 5 sampled residents reviewed for unnecessary medications.	F 867	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. No residents suffered adverse effects. The facility recognizes that all residents have the potential to be affected. The facility has developed a plan of correction using root cause analysis to specifically address the area of noted deficient practice related to Drug Regimen is free from unnecessary medications. The Administrator/designee will be responsible for organizing monthly Quality Assurance Performance Improvement Committee meetings to review the audit implemented as part of the plan of correction. This committee will be responsible for making recommendations on further plan of action to ensure compliance, including performing root	

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F 867	Continued From page 28 An interview was conducted on 04/27/23 at 5:30 PM with the Administrator. The Administrator revealed since she started in August 2022 there were several changes in administrative staff. The Administrator revealed Performance Improvement Plans (PIP) were put in place when issues were identified that included ongoing monitoring and in-service training of staff.	F 867	cause analysis of identified areas of concern. Additionally, this committee will be responsible for identifying other areas in which performance improvement may be necessary. Audit results from the plan of correction will be reviewed through monthly Quality Assurance Performance Improvement meetings and further action plans and audits will continue until substantial compliance is achieved. From then on, monthly Quality Assurance Performance Improvement meetings will help to ensure quality standards are met through continual performance analysis and the implementation of systematic efforts to improve those processes that do not meet acceptable levels. This will include self-monitoring of identified deficient practices that shall be reviewed during the monthly Quality Assurance Performance Improvement Committee meetings until significant corrections are noted and ongoing, as necessary by the Administrator or designee. Date of completion 5/24/2023	