STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/11/23 through 9/15/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #703C11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/11/23 through 09/15/23. Event ID# 703C11. The following intakes were investigated: NC00194665, NC00195733, NC00203107, NC00203628, NC00204697, NC00205828, NC00206088, and NC00206441. 17 of the 17 complaint allegations did not result in deficiencies.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		10/4/23

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

Electronically Signed | 10/05/2023

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F 623	Continued From page 1	F 623		

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and

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F 623	Continued From page 2 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 623	The statements made on this plan of	

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F 623	Continued From page 3 facility failed to notify the family member and the Long-Term Care Ombudsman in writing when 1 of 3 sampled residents (Resident #253) was discharged to the hospital. The findings included: Resident #253 was admitted in the facility on 6/17/23 with diagnoses that included Parkinson's disease and dementia. A family member was listed in the electronic health record as Resident #253's Responsible Party (RP). Attempts to reach the RP were unsuccessful, however Emergency Contact #2 (family member) was contacted via telephone. The significant change Minimum Data Set assessment dated 7/9/23 revealed Resident #253 was cognitively impaired. The medical record revealed the resident was transferred to the hospital on 7/13/23 due to a change in condition. Resident #253 did not return to the facility . Resident #253 was discharged to a different facility upon discharge from the hospital per family request. There was no documentation in Resident #253's medical record that a written notice of transfer was provided to either the RP or Ombudsman. On 9/12/23 at 3:36 PM a phone interview was conducted with Resident #253's Emergency Contact #2. She stated the family made the decision to transfer Resident #253 to another facility from the hospital because they were dissatisfied with the care provided by the facility. The Administrator was interviewed on 9/14/23 at	F 623	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. F623 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10/2/2023, the Social Services Director provided written notice of discharge to Resident #253 and the resident's representative. On 10/2/2023, the Social Services Director provided notification to the Ombudsman of Resident #253□s discharge. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 09/22/2023, the Social Services Director identified residents that were potentially impacted by this practice by completing an audit of the discharges in the last 30 days. This audit consisted of reviewing the transfer discharge residents where the resident and the resident□s representative had not received written notice of discharge for facility-initiated discharge. On 09/22/2023, the Social	

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F 623	Continued From page 4 5:15 PM and stated the procedure was for all Discharge/Transfer notifications for residents to be sent to the Ombudsman monthly. He was not able to provide the Discharge/Transfer notification for Resident #253. On 9/14/23 at 5:20 PM in an interview with the Social Worker (SW), she stated it was her responsibility to provide the Discharge/Transfer notification to the Ombudsman and RP when a resident was discharged. She further stated she filled out a copied form that contained the Ombudsman's name and address and the Administrator's signature. She explained she filled in the blanks, made a copy of the form, and put it in a discharge packet and sent the discharge packet with a resident upon discharge. She added if the discharge happened on a weekend or holiday, she completed the packet and sent it to the Ombudsman and RP on the next business day. She stated she called the resident's RP but did not provide a written Discharge/Transfer notification for Resident #253.	F 623	Services Director mailed written notice of discharge to the resident representatives of all residents to ensure that they received a transfer/discharge notice. Additionally, the Social Services Director reviewed all residents who had been transferred or discharged from the facility in the past 30 days to ensure notification of the discharges was sent to the Ombudsman. On 09/22/2023 the Social Services Director sent the Ombudsman notification of all residents who were transferred or discharged from the facility in the past 30 days. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/19/2023, the Administrator began education of licensed nurses Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) and the Social Services Director on the requirement to provide written notice of discharge to the resident or the resident's representatives. Additionally, on 09/19/2023, the Social Services Director was educated on the requirement of notifying the Ombudsman of all facility transfers and discharges. This in-service was incorporated in the new employee facility orientation for the employees identified above. This 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 will not be allowed to work until training has	

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F 623	Continued From page 5	F 623	been completed by 10/04/2023. 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 Administrator or designee will monitor compliance utilizing the F623 Quality Assurance Tool. The tool will monitor 5 resident transfers and discharges to ensure that each resident and the resident's representatives that transferred or discharged receives written notice of discharge. This will be monitored weekly x 4 weeks then monthly x 3 months. Additionally, the administrator or designee will monitor the monthly reporting to the Ombudsman to ensure he/she has received monthly notification of all residents transferred or discharged from the facility. This audit will be performed monthly times 3 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The 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 623	Continued From page 6	F 623	Date of Compliance: 10/04/23	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide the resident a written notification of the bed hold policy upon a resident's transfer to the hospital for 1 of 3	F 625	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	10/4/23

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F 625	Continued From page 7 residents (Resident #253) reviewed for hospitalization. Findings included: Resident #253 was admitted to the facility on 6/17/23. A family member was listed in the electronic health record as Resident #253's Responsible Party (RP). The significant change Minimum Data Set assessment dated 7/9/23 revealed Resident #253 was cognitively impaired. The medical record demonstrated the resident was transferred to the hospital on 7/13/23 due to a change in condition. Resident #253 did not return to the facility. No written notice of the facility's bed hold policy was documented to have been provided to the resident or the resident's Responsible Party. In an interview on 9/14/23 at 4:07 PM with the Business Office Manager she stated there was no bed hold notification sent with Resident #253 or provided to the family. She stated it was her responsibility to provide the notice and she did not provide one for Resident #253. On 9/14/23 at 5:10 PM a follow up interview with the Business Office Manager revealed that on admission she informed the family she was the primary contact for the family for bed holds if there was a discharge. She stated she did not send a bed hold notification unless the family was unable to come in and sign. She further stated if a discharge occurred on a weekend or holiday the family was notified the next business day. She added bed holds are her responsibility. She	F 625	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. F625 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/19/2023, the Business Office Manager provided written Bed Hold Notice to Resident #253 and the resident's representative with a certified mailed letter. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 09/19/2023, the Business Office Manager identified residents that were potentially impacted by this practice by completing an audit of the discharges in the last 30 days. This audit consisted of reviewing the transfer discharge residents where the resident and the resident□s representative had not received written Bed Hold Notice. On 09/19/2023, the Business Office Manager certified mailed written Bed Hold Notice to the resident representatives of all residents that did not receive a written Bed Hold Notice. 3. Measures/Systemic changes to prevent	

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F 625	Continued From page 8 explained facility procedure was to mail the bed hold notification to the family for them to sign with a return stamped envelope. She said she did not mail the bed hold letter and did not have a signed form for Resident #253. In an interview on 9/14/23 at 5:10 PM with the Administrator he provided the facility's procedure for bed hold notification when the resident or family is not available to sign. Line #6 of the procedure read "Mail the copy certified with return receipt requested to the responsible party. Include cover letter with form asking them to sign it and return immediately to the facility in the enclosed stamped envelope". He stated he did not have a receipt for a certified letter for Resident #253. He stated the Business Office Manager should have been sent a bed hold notification with Resident #253. In an interview on 9/14/23 at 5:30 PM the Corporate Nurse Consultant stated the bed hold notification notice should be sent with a resident when they are sent to the hospital or discharged.	F 625	reoccurrence of alleged deficient practice: On 09/19/2023, the Administrator began education of licensed nurses Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) and the Business Office Manager on the requirement to provide written Bed Hold Notice to the resident or the resident's representatives. This in-service was incorporated in the new employee facility orientation for the employees identified above. This 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 will not be allowed to work until training has been completed by 10/04/2023. 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 Administrator or designee will monitor compliance utilizing the F623 Quality Assurance Tool. The tool will monitor 5 resident transfers and discharges to ensure that each resident and the resident's representatives that transferred or discharged receives written notice of discharge. This will be monitored weekly x 4 weeks then monthly x 3 months. Additionally, the administrator or designee will monitor the monthly reporting to the Ombudsman to ensure he/she has received monthly notification of all	

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F 625	Continued From page 9	F 625	residents transferred or discharged from the facility. This audit will be performed monthly times 3 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/04/23	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 727	The statements made on this plan of	10/4/23

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F 727	Continued From page 10 facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day for 7 out of 72 days reviewed for staffing. The failure to have RN coverage for the facility had a high likelihood of impacting every resident in the facility. The facility also failed to prevent the Director of Nursing (DON) from serving as a charge nurse with a facility census of greater than 60 residents for two days, 8/20/23 and 7/30/23. The findings included: Review of the Posted Nurse Staffing as compared to the Staff Schedule/Assignment Sheets, and RN timecard reports revealed there was no RN coverage for eight consecutive hours for 9/10/23, 9/3/23, 8/12/23, 8/6/23, 8/5/23, 7/23/23, 7/2/23. Further review of the Posted Nurse Staffing as compared to the Staff Schedule/Assignment Sheets and RN timecard reports for the same period revealed the DON served as the charge nurse on 8/20/23 with a facility census of 103 and on 7/30/23 with a facility census of 104. An interview was conducted on 9/13/23 at 3:09 PM with the DON. She stated she did not have an RN on 9/10/23, 9/3/23, 8/12/23, 8/6/23, 8/5/23, 7/23/23, 7/2/23. She further stated the agency did not have an RN available at that time. She stated she has had a hard time finding an RN to hire. The DON also stated that the facility currently has only 3 Registered Nurses on staff. She stated she was not aware that she could not be listed as the only RN on duty for the day if the facility census was greater than 60. An interview was conducted on 9/13/13 and	F 727	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. F727 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/18/23, the Scheduling Coordinator placed a Registered Nurse for each day for eight hours a day. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 9/25/23, the Administrator identified residents that were potentially impacted by this practice by completing an audit of the last 28 days to see if there was Registered Nursing coverage for 8 hours a day. No other dates were identified by the administrator of having no RN in house for a minimum of 8 hours daily. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 9/19/23, the Regional Director of Operations began education of the Administrator and the Scheduling	

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F 727	Continued From page 11 9/15/23 at 1:35 PM with the facility Nurse Consultant who stated she was unaware of the RN staffing issues at the facility. She did state that she is aware of the regulation that stated the facility had to provide RN coverage for at least 8 consecutive hours a day and that the DON can't serve as a charge nurse with a facility census greater than 60.	F 727	Coordinator on the requirement to provide 8 hours of Registered Nursing coverage a day. 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 F727 Quality Assurance Tool. The tool will monitor 7 days of Registered Nursing coverage to ensure that the facility has 8 consecutive hours of Registered Nursing coverage. This will be monitored weekly x 4 weeks then monthly x 3 months. The Regional Director of Operations will review the QI minutes for continued compliance. Date of Compliance: 10/04/23	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.14% for 1 of 3 residents (Resident #354)	F 759	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	10/4/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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F 759	Continued From page 12 observed during the medication administration observation. The findings included: 1. Resident #354 was admitted to the facility on 8/21/23. His cumulative diagnosis included Parkinson's disease. On 9/12/23 at 9:06 A.M., Nurse #3 was observed as she prepared and administered medication to Resident #354. The administered medications included one tablet of Azilect 1 milligram (mg). (Azilect is used to treat the symptoms of Parkinson's disease). Record review of Resident #354's physician orders included a current medication order for Azilect 0.5mg, give one tablet by mouth in the morning. An interview was conducted on 9/12/23 at 9:43 A.M. with Nurse #3. During the interview the packaged bubble sheet for Azilect, sent from the pharmacy and stored on the medication cart, was reviewed with Nurse #3. The package for Azilect showed 1 tablet of Azilect 1 mg sealed in each bubble slot. The label on the Azilect package was compared with the physician orders. Nurse #3 confirmed the physician order read administer Azilect 0.5mg each morning and she had administered Azilect 1mg to Resident #354. Nurse #3 stated she had only verified Resident #354's name and the name of the medication on the pharmacy package during the Resident #354's morning administration pass on 9/12/23. Nurse #3 further stated she was responsible for also verifying the medication dose prior to administration. During the interview, Nurse #3	F 759	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. F759 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/26/23, the Charge Nurse notified the Medical Director and the family of the medication error. Resident # 354□s incorrect dosage of medication was removed from the medicine cart by the Director of Nursing. The Director of Nursing then called the pharmacy to get the correct dosage of medication for Resident # 354. For resident # 354, on 10/04/23 nurse #3 was educated by the Director of Nurses on the correct procedure for administering ordered medications to include following the six rights of medication administration to assure medications are administered as ordered by the physician. The nurse #3 was also educated on notification of the physician if a medication is not available as ordered and how to utilize the backup pharmacy to assure medications are administered as ordered. 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 759	Continued From page 13 explained on 9/12/23 she had not verified the dose of the medication because she had previously administered Resident #354 his medications from the same packaging and she thought the medication was the right dose. An interview was conducted on 9/13/23 at 4:14 P.M. with the Director of Nursing (DON). During the interview the DON stated the nurse administering medications should identify discrepancies in medication dosing between the medications on the medication cart and physician orders prior to administering the medication to residents. The DON further explained when the physician order did not match the medication on the medication cart, Nurse #3 was responsible for verifying the dose of Resident #354's Azilect with the pharmacist and/or the physician prior to administering Resident #354 his medication on 9/12/23. The DON was unsure why this had not occurred for Resident #354. 2. On 9/12/23 at 9:06 A.M., Nurse #3 was observed as she prepared and administered medication to Resident #354. The administered medications included one tablet of folic acid 1,000 micrograms (mcg). The medication was obtained from a house stock bottle stored on the medication cart. Resident #354's physician orders included a current medication order for folic acid tablet 800 mcg, give 1 tablet by mouth in the morning for supplement. An interview was conducted on 9/12/23 at 9:43 A.M. with Nurse #3. During the interview with Nurse #3, the stock bottle of folic acid was	F 759	On 10/3/23, the Director of Nursing began a 100% match back audit which included going through each medication cart in the facility, which was five medication carts, and ensuring that each medication in the medication cart matched the orders in the Medication Administration Record. This audit was completed by reviewing 100% of current residents orders to ensure residents received the correct medications. Director of Nursing removed all medications from carts that were inaccurate, sent back to pharmacy and the doctor was notified. Any medication orders were initiated by nursing staff on 10/3/23. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 9/19/23 the Director of Nursing began education of all full time, part time, per-diem nurses/agency nurses and medication aides. Education will be focused on medication administration as ordered by physicians or mid-level practitioners to include following the six rights of medication administration, following physician orders and applying medications as ordered to the correct body site. This information has been integrated into the standard orientation training and in the required inservice 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 inservice	

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F 759	Continued From page 14 reviewed and compared with physician orders. Nurse #3 confirmed the physician's order read administer one tablet folic acid 800 mcg each morning and she had administered folic acid 1,000 mcg to Resident #354. Nurse #3 stated folic acid was a stock item on the medication cart and she had not verified the dose of folic acid on the medication bottle with Resident #354's physician order prior to administering Resident #354 his medications. She explained it was her responsibility to check the folic acid dose on the physician order against the folic acid stock medications on her cart with each medication administration. During the interview, Nurse #3 stated she thought the stock item of folic acid on her medication cart was the same dose as the folic acid ordered by the physician when she had prepared Resident #354's medications for his morning medication administration. An interview was conducted on 9/13/23 at 4:14 P.M. with the Director of Nursing (DON). During the interview the DON stated the nurse administering medications should identify discrepancies in medication dosing between the medications on the medication cart and physician orders prior to administering the medication to residents. The DON further explained Nurse #3 was responsible for verifying the dose of Resident #354's folic acid prior to administering Resident #354 his medication on 9/12/23. The DON was unsure why this had not occurred for Resident #354.	F 759	training by 10/04/2023 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 Assistant Director of Nurses will randomly observe medication pass for 5 residents a week for adherence to orders by physicians or mid-level practitioners. The Director of Nurses or designee will complete the Quality Assurance audit tool for adherence to the facility medication administration policy and process weekly x 4 then monthly x 3. 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 QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/04/23	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		10/4/23

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F 760	Continued From page 15 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director, Nurse Practitioner, and Pharmacist interviews, the facility failed to prevent a significant medication error by failing to administer a prescribed medication for Parkinson's disease at the dose ordered by a physician for 11 of 11 doses administered for 1 of 1 resident (Resident #354) reviewed for medication errors. Findings Included: Resident #354 was admitted to the facility on 8/21/23. His cumulative diagnosis included Parkinson's disease (a disease of the central nervous system that affects movements, often including tremors). Physician order dated 8/29/23 read Azilect (a medication used to treat the symptoms of Parkinson's disease) oral tablet 0.5 milligrams (mg) give one tablet by mouth in the morning for Parkinson's disease. The start date was 8/30/23 at 9:00 A.M. Review of the admission Minimum Data Set (MDS) dated 9/5/23 showed Resident #354 was cognitively intact. Review of the Medication Administration Record (MAR) for 8/30/23 through 9/12/23 revealed Azilect was documented as follows. - 8/30/23 at 9:00 A.M. not administered by Nurse #3; medication was unavailable - 8/31/23 at 9:00 A.M. administered by	F 760	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. F760 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/26/23, the Charge Nurse notified the Medical Director and the family of the medication error. Resident # 354□s incorrect dosage of medication was removed from the medicine cart by the Director of Nursing. The Director of Nursing then called the pharmacy to get the correct dosage of medication for Resident # 354. 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. On 10/3/23, the Director of Nursing began	

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F 760	Continued From page 16 Nurse #3 - 9/1/23 at 9:00 A.M. not administered by Nurse #3; resident had nausea/vomiting - 9/2/23 at 9:00 A.M. administered by Nurse #6 - 9/3/23 at 9:00 A.M. administered by Nurse #7 - 9/4/23 at 9:00 A.M. administered by Nurse #3 - 9/5/23 at 9:00 A.M. administered by Nurse #8 - 9/6/23 at 9:00 A.M. administered by Nurse #3 - 9/7/23 at 9:00 A.M. not administered by Nurse #3; resident out of the facility. - 9/8/23 at 9:00 A.M. administered by Nurse #3 - 9/9/23 at 9:00 A.M. administered by Nurse #9 - 9/10/23 at 9:00 A.M. administered by Nurse #10 - 9/11/23 at 9:00 A.M. administered by Nurse #3 - 9/12/23 at 9:00 A.M. administered by Nurse #3 An interview was attempted with Resident #354 on 9/15/23 at 7:40 A.M, 9/15/23 at 10:40 A.M., and 9/15/23 at 11:35 A.M. The interview was unsuccessful. On 9/12/23 at 9:06 A.M., Nurse #3 was observed as she prepared and administered medication to Resident #354. The administered medications included one tablet of Azilect 1 mg. An interview was conducted on 9/12/23 at 9:43 A.M. with Nurse #3. During the interview the packaged bubble sheet for Resident #354's	F 760	a 100% match back audit which included going through each medication cart in the facility, which was five medication carts, and ensuring that each medication in the medication cart matched the orders in the Medication Administration Record. This audit was completed by reviewing 100% of current residents orders to ensure residents received the correct medications. DON removed all medications from carts that were inaccurate, sent back to pharmacy. MD notified. Any medication orders were initiated by nursing staff on 10/3/23 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 9/19/23 the Director of Nursing began education of all full time, part time, per-diem nurses/agency nurses and medication aides. Education will be focused on medication administration as ordered by physicians or mid-level practitioners to include following the six rights of medication administration, following physician orders and applying medications as ordered to the correct body site. The pharmacy consultant will complete medication administration pass observations with licensed nurses/medication aides and report the findings to the Director of Nurses to assure compliance is sustained. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 760	Continued From page 17 Azilect was reviewed with Nurse #3. The packaged bubble sheet for Azilect showed 1 tablet of Azilect 1 mg sealed in each bubble slot. The label read in part "Take 1 tablet by mouth every morning." The label on the Azilect package was compared with the physician orders. Nurse #3 confirmed the physician order read administer Azilect 0.5mg each morning and on 9/12/23 during Resident #354's 9:00 A.M. medication pass, she had administered Azilect 1mg to Resident #354. Nurse #3 stated she had only verified Resident #354's name and the name of the medication on the pharmacy package. During the interview, Nurse #3 stated the nurse who administered medication to residents were responsible for verifying the medication dispensed from the bubble sheet matched the resident's name, the medication name, and the dosage ordered by the physician. During the interview, Nurse #3 stated she had not verified the dose of Azilect removed from the bubble sheet matched the physician order because she had previously administered Resident #354 his medications from the same packaging and she thought the medication was the right dose. During the interview, Nurse #3 stated Resident #354 had not voiced any concerns to her of not feeling well on 9/12/23 and to the best of her knowledge Resident #354 had no complaints of not feeling well since his admission. During a follow-up interview conducted on 9/15/23 at 11:44 A.M. with Nurse #3, she stated she notified the Nurse Practitioner (NP)of the error on Resident #354's Azilect's label from the pharmacy on 9/12/23 at about 10:30 A.M. Nurse #3 explained the NP told her to not use the medication in the bubble package until it had been corrected and the NP advised her to contact	F 760	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 10/04/2023 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 Nursing or designee will monitor utilizing the Medication Administration Record and F-760 Quality Assurance Tool. The monitoring will include a review of 5 residents a week for medications dosage, weekly x 4 weeks and then monthly x 3 months. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/04/23	

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F 760	Continued From page 18	F 760		

the pharmacy to have a new bubble package of Azilect sent with the dose of 0.5mg.

An interview was attempted with Nurse #6 who was assigned to Resident #354 on 9/2/23 during the 9:00 A.M. medication administration pass was unsuccessful.

An interview was attempted with Nurse #7 who was assigned to Resident #354 on 9/3/23 during the 9:00 A.M. medication administration pass was unsuccessful.

An interview was conducted with Nurse #8, who was assigned to Resident #354 on 9/5/23 during the 9:00 A.M. medication administration pass. During the interview, Nurse #8 stated she works throughout the facility, and she does not specifically recall Resident #354's medication administration pass on 9/5/23 at 9:00 A.M. During the interview, Nurse #8 stated when she administered medication, she checked the name and dosage of medication on the packaged bubble sheet and compared the information with the physician order. Nurse #8 explained if she had identified the dose did not match, she would have cut the Azilect in half and administered only half the tablet to equal the correct dose. Nurse # 8 was unable to recall if the Azilect tablet had been cut in half.

An interview was attempted with Nurse #9 who was assigned to Resident #354 on 9/9/23 during the 9:00 A.M. medication administration pass was unsuccessful.

An interview was conducted on 9/15/23 at 11:50 A.M. with Nurse #10 who was assigned to Resident #354 on 9/10/23 during the 9.00 A.M.

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F 760	Continued From page 19	F 760		

medication administration pass. During the interview, Nurse #11 stated she does not recall Resident #354 or administering him his medications on 9/10/23. Nurse #11 explained when the pharmacy sent bubble packages with the resident's medications, each bubble contained the correct dosage of medication for each medication administration. Nurse #11 stated she would have pushed the tablet out of one sealed bubble and administered the medication to the resident. During the interview, Nurse #11 stated she had never cut medication in half when she removed the medication from the bubble and explained if half a pill was needed the pharmacy would have sent a half a pill in each bubble. Nurse #11 stated she does not recall Resident #354 having any concerns of not feeling well when she was assigned to his care on 9/10/23.

An interview was conducted on 9/14/23 at 11:03 A.M. with the Pharmacist. During the interview, the Pharmacist stated they received an order for Resident #354's Azilect 0.5mg on 8/29/23. The order was filled incorrectly by the pharmacy when the numeric code used to identify the medication by manufacturer and strength was incorrect, and a packaged bubble sheet of Azilect 1mg was sent to the facility on 8/30/23. The Pharmacist explained Azilect was not a medication the facility had on hand in a backup pharmacy at the facility and the order had to be filled and delivered by the pharmacy staff. The Pharmacists reviewed Resident #354's record and stated there were no phone calls logged from the staff at the facility on the dosing of Resident #354's Azilect being inaccurate until 9/12/23. She explained at this time the pharmacy sent a new bubble sheet for Resident #354 which contained Azilect 0.5mg. The Pharmacist explained Resident #354 would

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F 760	Continued From page 20	F 760		

not have been affected by the higher dose of Azilect because Resident #354's record showed he did not have a diagnosis of liver damage.

An interview was completed on 9/14/23 at 4:22 P.M. with the Nurse Practitioner (NP). During the interview, the NP stated on 9/12/23 she was in the building working when Nurse #3 showed her Resident #354's medication bubble sheet for Azilect and explained the dosage did not match the physician order. The NP stated she reviewed the physician order for Resident #354's Azilect and saw the order read Azilect 0.5mg every morning and the bubble sheet read Azilect 1mg every morning. The NP advised Nurse #3 to call the pharmacy and make them aware of the discrepancy. The NP further stated when she worked on 9/12/23, no concerns were brought to her about Resident #354 not feeling well. The NP further stated there would have been no negative outcome for Resident #354 had he taken 1mg of Azilect instead of 0.5mg of Azilect.

An interview was conducted on 9/13/23 at 4:14 P.M. with the Director of Nursing (DON). During the interview the DON stated during each medication administration pass, the nurse who administered medications was responsible for verifying the dosage of dispensed medication with the physician order prior to administering the medication to residents. The DON further explained when the physician order did not match Resident #354's dispensed dose of Azilect on the medication cart, the assigned nurse was responsible for verifying the dose of Resident #354's Azilect with the pharmacist and/or the physician prior to administering Resident #354 his medication. The DON was unsure why this had not occurred for Resident #354's Azilect.

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F 760	Continued From page 21 An interview was completed on 9/13/23 at 12:55 P.M. with the Medical Director. During the interview, the Medical Director stated when staff did not have the correct dose of medication to administer to a resident, the staff were responsible for contacting either herself or the Nurse Practitioner and making them aware so additional orders could be given as needed. The Medical Director stated Azilect was used to control tremors in patients with Parkinson's disease and she explained Resident #354 would not have been harmed when he received a 1 mg dose instead of a 0.5mg dose of Azilect.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		10/4/23

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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 761	Continued From page 22 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly discard three expired vaccines, Prevnar 20 (Pneumococcal 20-valent Conjugate Vaccine) that were available for use in 1 of 3 medication rooms (100 hall nurse's station). The findings included: An observation on 9/15/23 at 3:04 PM of the refrigerator in the medication room on the 100-hall revealed three unused, single dose syringes of Prevnar 20 (Pneumococcal 20-valent Conjugate Vaccine) that had an expiration date of 8/28/23. An interview on 9/15/23 at 3:10 PM with the Director of Nursing (DON) revealed the last resident to receive a Prevnar 20 vaccine was over a month ago. The DON explained there was not a specific nurse that oversees stocking medications in the refrigerator and checking expiration dates. She stated the nursing staff were responsible for making sure there were no expired medications or vaccines in the refrigerator.	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 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. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/15/23, the three unused, single dose syringes of Prevnar 20 (Pneumococcal 20-valent Conjugate Vaccine) was removed from the refrigerator in the medication room on the 100 Hall and sent back to the pharmacy. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. On 9/15/23, the Director of Nursing audited all medication carts, treatment	

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carts, and medication rooms to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 9/22/23. No resident was found to be affected by the deficient practice.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education:
On 9/19/23, the Director of Nursing began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff on the following topics:

" Checking medications for expiration date prior to administering the medication.
" Labeling medications when opened with date open as indicated.
" Pharmacy recommended storage for selected items.

This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This 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 will not be allowed to work until training has been completed by 10/04/2023.

4. Monitoring Procedure to ensure that

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F 761	Continued From page 24	F 761	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the medication and treatment carts and the medication room is free of expired medications for. This monitoring will consist of monitoring each cart once weekly. Reports will be presented to the weekly Quality Assurance committee by the DON 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, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/04/23	
F 867 SS=E	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	F 867		10/4/23

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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 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

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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.

§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

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F 867	Continued From page 27 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 (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 observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification, complaint, and infection control surveys completed on 7/23/21 and 9/24/21. This was for 2 deficiencies that were cited in the areas of Label/Store Drugs and Biologicals (761) which was cited on 7/23/21 and recited on the current recertification and	F 867	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	

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F 867	Continued From page 28 complaint survey of 9/15/23; and Residents are Free of Significant Medication Errors (760) which was cited on 9/24/21 and recited on the current recertification and complaint survey of 9/15/23. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QAA). The findings included: This citation is cross-referenced to: F760: Based on record review and staff, Medical Director, Nurse Practitioner, and Pharmacist interviews, the facility failed to prevent a significant medication error by failing to administer a prescribed medication for Parkinson's disease at the dose ordered by a physician for 11 of 11 doses administered for 1 of 1 resident (Resident #354) reviewed for medication errors. During the complaint investigation survey on 9/24/21, the facility failed to initiate the administration of two intravenous antibiotics after receipt of a physician's order for 1 of 1 resident reviewed who required treatment with an intravenous antibiotic medication. F761: Based on observations and staff interview, the facility failed to properly discard three expired vaccines, Prevnar 20 (Pneumococcal 20-valent Conjugate Vaccine) that were available for use in 1 of 3 medication rooms (100 hall nurse's station).	F 867	deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On, 9/19/23 the Regional Director of Operations educated the Administrator on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Label/Store Biologicals (761) and Free of Significant Medication Errors (760). These deficiencies were cited again on the current recertification survey completed on 9-15-23. 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: Label/Store Biologicals (F-761) Free of Significant Medication Errors (F-760) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 9/27/23 to review the deficiencies from the September 11 □ September 15, 2023 annual recertification survey and reviewed the citations. 3. Measures/Systemic changes to prevent	

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F 867	Continued From page 29 During the recertification, complaint investigation, and infection control survey on 7/23/21, the facility failed to discard expired medications stored in 3 of 3 medication carts (200 Hall Med Cart, 500 Hall Med Cart, and 400 Hall Med Cart) and in 1 of 2 medication rooms (200/300 Hall Med Room) observed. During an interview on 9/15/23 at 2:30 PM, the Administrator revealed the QAA committee meets monthly and whenever needed. He stated negative trends were brought to the QAA committee's attention via staff, residents, families, and/or other members. The Administrator stated that during each monthly QAA meeting, a non-QAA staff from one of the departments is invited to attend monthly meetings to teach them the QAPI process including the education, audit and monitoring process as quality control/plan of care.	F 867	reoccurrence of alleged deficient practice: On 9/27/23 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 committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Label/Store Biologicals (761) and Free of Significant Medication Errors (760). 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. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 10/04/23. 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 4 weeks then monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee.	

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F 867	Continued From page 30	F 867	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 with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The Regional Director of Operations will review the QI minutes for continued compliance. Date of Compliance: 10/04/23	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to maintain the pull cord of a bathroom call light for 2 of 2 front hall public restrooms. Findings included:	F 919	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	10/4/23

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F 919	Continued From page 31 On 9/11/23 at 10:00 AM an observation of the front lobby public restrooms revealed the emergency call light cords were in the activated/reset position. In each restroom the emergency pull cord was fully extended, and the reset button was in the out position. There were no call lights mounted outside the restrooms. On 9/13/23 at 3:30 PM an observation was made of an alert and oriented resident, Resident # 94, using one the front lobby restrooms. Resident #94's quarterly MDS (Minimum Data Set) dated 8/26/23 revealed he was admitted on 6/17/23 and he was cognitively intact. On 9/13/23 at 2:35 PM an observation of the front lobby public restrooms revealed the emergency call lights were in the activated/reset position with the cords hanging down to the floor. An interview with the receptionist on 9/15/23 at 1:13 PM revealed that the lobby restrooms were for staff and visitors, but residents used them as well. She stated she tried to redirect residents to their rooms when she observed them entering the lobby restrooms. During an interview with the Maintenance Director on 9/15/23 at 1:15 PM he stated he had been in the position of Maintenance Director for almost two years. He further stated that to his knowledge the emergency call lights in the lobby restrooms had not been in working order when he took over the position and they were not connected to the facility call system. He said he believed it had been an oversight when the front lobby and restrooms were renovated. He stated he expected the safety cords to be connected to the	F 919	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. F919 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/22/2023, the Maintenance Director immediately placed locks on both bathrooms in the lobby. Keys to access the bathrooms in the lobby were placed behind the receptionist desk. 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 call light accessibility and function. A 100% audit was conducted for all call lights in the facility to insure accessibility and function by the Maintenance Director on 9/22/2023. The results found were that three communal bathrooms did not have working call light systems. The Maintenance Director placed locks on those three communal bathrooms and placed keys behind the nurses station. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 919	Continued From page 32 emergency call lights and all be in good working order. An interview conducted on 9/15/23 at 1:25 PM with Nurse Aide #1 revealed that Resident # 94 was able to transfer to the toilet with the aid of a slide board he kept on the back of his wheelchair. During an interview on 9/15/23 at 3:45 PM, Resident # 94 stated he used the front lobby restroom when he came back into the facility from outside visits or appointments because his room was on the hall farthest from the lobby. During an interview with the Corporate Nurse Consultant on 9/15/23 at 4:00 PM, she stated all emergency call lights should always be in working condition.	F 919	On 09/19/2023, the Administrator began education of the Maintenance Director on the requirement of the working call bell system in the facility. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 10/04/23. 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 F919 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. Reports will be presented to the Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager. The Medical Director and Pharmacist attend the quarterly Quality Assurance Meeting. Date of Compliance: 10/04/2023	