STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 from 10/09/23 through 10/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MUKB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 10/09/23 through 10/13/23. The following intakes were investigated NC00207486, NC00207640, NC00207734, NC207870, and NC00208420. 3 of the 11 complaint allegations resulted in deficiency. Event ID# MUKB11.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the resident, staff and the Medical Director, the facility failed to provide nail care to 1 of 2 residents (Resident #85) reviewed for assistance with activities of daily living. The findings included: Resident #85 was admitted to the facility on 3/22/23 with diagnoses that included chronic gout with tophus (buildup of uric acid around joints). Resident #85's care plan revised on 3/22/23 indicated Resident #85 had an activities of daily	F 677	1) On 10/11/23, the Unit Managers (UMs) provided nail care for Resident #85 to ensure nails were clean and trimmed. The physician was notified of nail concerns and provided treatment order for Ciclopirox antifungal ointment to affected right hand fingernails until resolved. 2) On 10/31/23, the UMs provided nail care for all dependent resident to ensure fingernails and toenails are clean and trimmed. Care plans updated for residents preferring long nails. The Physician notified of residents with nail concerns	11/3/23

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

Electronically Signed | 11/02/2023

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

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F 677	Continued From page 1 living (ADL) self-care performance deficit related to impaired balance due to severe tophus feet deformities. Interventions included for nursing staff to provide ADL assistance per facility schedule and as needed. The quarterly Minimum Data Set (MDS) assessment dated 9/5/23 indicated Resident #85 was cognitively intact and required limited assistance with personal hygiene. An observation and interview with Resident #85 on 10/9/23 at 9:44 AM revealed he had long, thick fingernails on the right hand which extended approximately ¼ inch past the tips of his fingers. His nails on the left hand were not thick but they were long and also extended approximately ½ inch past the tips of his fingers. Brown matter was observed underneath his left fingernails. Resident #85 stated he last had a shower on 10/6/23 and he wanted his fingernails cut, but staff told him a foot doctor would have to trim his nails. An observation of Resident #85 on 10/11/23 at 12:23 PM revealed he continued to have long, thick nails on the right hand and long nails on the left hand. During the observation, Resident #85 stated he wanted something to be done about his long nails and they needed to be taken care of. He also stated that he had always had thick nails on the right hand even when he was admitted at the facility. Resident #85 shared that he used to take an anti-fungal medication, but it was affecting his liver, so he had to stop taking it. An interview with Nurse Aide (NA) #1 on 10/11/23 at 4:27 PM revealed she had given Resident #85 a shower on 10/10/23 and had noticed his long	F 677	and podiatry referrals made as appropriate. 3) Effective 11/3/23, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses and nurse aides on providing Activities of Daily Living (ADL) nail care for dependent residents. Education included nurse aides providing nail care during shower/bathing times and as needed and identified during routine daily ADL care. Nails will be clean, trimmed, and free of jagged edges unless otherwise preferred by the residents' plan of care. Nail concerns, such as thick, hard to trim nails or refusals for care will be reported by the nurse aide to the licensed nurse who will provide care if indicated or notify the Provider as appropriate for new orders. Newly hired facility and agency licensed nurses and nurse aides will receive education upon hire and prior to next shift worked. 4) The UM will make observations of five (5) dependent residents to ensure appropriate nail care is provided. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks. The Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with nail care for dependent residents.	

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F 677	Continued From page 2	F 677	Compliance date: 11/3/23	

nails. NA #1 stated that Resident #85's nails looked horrible, and she tried to do nail care on him, but he did not want to. NA #1 stated that Resident #85 said to her that a specialist or a nail doctor was coming soon to take care of his nails.

A follow-up interview with Resident #85 at 10/11/23 at 4:36 PM revealed he did not refuse to get his fingernails cut when he received a shower on 10/10/23. Resident #85 stated he wanted them to get taken care of. During the interview with Resident #85, NA #1 was asked to clarify why she said he refused to get his nails cut. NA #1 stated she didn't know that Resident #85 wanted her to cut his nails on the left hand which were not thick. NA #1 stated to Resident #85 that she would trim his fingernails on the next day of his shower which was scheduled for 10/13/23.

An interview with Nurse #4 on 10/12/23 at 9:00 AM revealed he took care of Resident #85 on 10/9/23 and saw that Resident #85's nails needed to be trimmed. Nurse #4 stated he could have trimmed Resident #85's nails but it slipped his mind and he forgot to offer if Resident #85 wanted them trimmed. Nurse #4 stated nails were supposed to be trimmed on shower days and the nurse aides could have clipped his fingernails.

An interview with Unit Manager (UM) #1 on 10/12/23 at 11:12 AM revealed she had seen Resident #85's nails before but she was not sure why they have not been trimmed. UM #1 stated that she noticed Resident #85's nails were long, and he let her cut the nails on his left hand. She also stated that Resident #85 did not want her to trim his right fingernails and told her that a special equipment would be used to trim his right

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F 677	Continued From page 3 fingernails. An interview with the Medical Director (MD) on 10/11/23 at 3:52 PM revealed he was not sure why Resident #85 was not being treated for his thick nails and he was not sure about a podiatrist needing to trim his right fingernails. The MD explained that oral medications could cause issues with the liver, but topical medication would not be harmful and could help treat Resident #85's thick nails. The MD stated he was not sure why the nurses had not brought this to his attention. An interview with the Director of Nursing (DON) on 10/12/23 at 1:19 PM revealed if a resident was not diabetic, then the nurses or nurse aides could trim nails and they needed to cut them if they were able to cut the nails. The DON stated she was not sure why the nurses did not report Resident #85's long and thick nails to the provider unless they thought these were normal for him.	F 677		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		11/3/23

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F 687	Continued From page 4 by: Based on record review, observation, and resident and staff interviews, the facility failed to ensure toenails were trimmed and refer a resident to podiatry services for 1 of 1 resident (Resident #85) reviewed for foot care. The findings included: Resident #85 was admitted to the facility on 3/22/23 with diagnoses that included chronic gout with tophus (buildup of uric acid around joints). Resident #85's care plan revised on 3/22/23 indicated Resident #85 had an activities of daily living (ADL) self-care performance deficit related to impaired balance due to severe tophus feet deformities. Interventions included for nursing staff to provide ADL assistance per facility schedule and as needed. A review of Resident #85's medical record indicated a physician's order dated 3/22/23 of: May initiate evaluation and treatment by podiatry per regulation. There were no podiatry consults in Resident #85's medical record. The quarterly Minimum Data Set (MDS) assessment dated 9/5/23 indicated Resident #85 was cognitively intact and required limited assistance with personal hygiene. An interview with Resident #85 on 10/9/23 at 9:44 AM revealed his toenails needed to be trimmed and he had a thick nail on his left great toe. He stated that he last had a shower on 10/6/23 and he asked the staff to trim his toenails, but they told him that a foot doctor would have to do it even though he was not diabetic. Resident #85	F 687	1) On 10/11/23, the Unit Manager provided nail care for Resident #85 to ensure toenails were clean and trimmed. Physician notified of toenail concern and order implemented for antifungal ointment. A referral was made for podiatry services and services provided on 10/17/23. Resident #85 will continue to receive routine and emergency foot care as consented by the resident. 2) On 10/31/23, the Unit Managers (UMs) provided toenail care for all dependent residents to ensure nails are clean and trimmed. Care plans updated for residents refusing nail care or preferring long nails. The Medical Director (MD) or Nurse Practitioner (NP) were notified of residents assessed with nail concerns and new treatment orders or podiatry orders received and initiated as appropriate. 3) Effective 11/3/23, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses, nurse aides and the Social Worker on the process for ensuring proper foot care for all current facility residents. Education included nurse aides providing nail care during shower/bathing times and as needed and identified during routine daily activities of daily living (ADL) care. Nails should be clean, trimmed, and free of jagged edges unless otherwise preferred by the residents' plan of care. Nail concerns, such as thick, hard to trim nails should be reported by the nurse aide	

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F 687	Continued From page 5 stated his toenails had been this way since admission to the facility and he had never been seen by a podiatrist. An observation of Resident #85 on 10/11/23 at 12:23 PM revealed his left great toenail was long, thick, and extended approximately ½ inch past the tip of his toe in a slant. His left middle toenail was also long, thick, and extended approximately ½ inch past the tip of his toe. His right great toenail had jagged edges while the second and fifth toenails were long, thick, and extended approximately ½ inch past the tips of his toes. During the observation, Resident #85 stated he wanted something to be done about his long nails and they needed to be taken care of. An interview with Nurse Aide (NA) #1 on 10/11/23 at 4:27 PM revealed she had given Resident #85 a shower on 10/10/23 and had noticed his long toenails. NA #1 stated that Resident #85's nails looked horrible, but she didn't know what to do about his toenails. An interview with Nurse #4 on 10/12/23 at 9:00 AM revealed he took care of Resident #85 on 10/9/23 and saw Resident #85's long toenails. Nurse #4 stated nails were supposed to be trimmed on shower days and the nurse aides could have clipped his toenails if they were able to because if he was not diabetic. An interview with the Social Worker (SW) on 10/12/23 at 12:36 PM revealed she was responsible for scheduling the podiatry clinic and the last time the podiatrist went to the facility was on 9/5/23 and 9/7/23. The SW stated Resident #85 had not been seen by the podiatrist, but he was on the list to be seen on the next podiatry	F 687	to the licensed nurse who will notify the physician as appropriate and podiatry referrals made if indicated. The Social Worker will receive and coordinate routine (every 61 days) and emergency podiatry referrals and maintain an updated log of routine and emergency service dates. Newly hired facility and agency licensed nurses, nurse aides and Social Workers will receive education upon hire and prior to next shift worked. 4) The Minimum Data Set (MDS) will monitor five (5) residents to ensure appropriate foot care is being provided by the facility. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks. The Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with foot care. Compliance date: 11/3/23	

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F 687	Continued From page 6 clinic on 10/17/23. The SW said Resident #85 came up to her recently and asked to see the podiatrist, but he did not specify the reason for it. The SW stated that she was still learning and was not sure how often the podiatrist came to the facility. An interview with Unit Manager (UM) #1 on 10/12/23 at 11:12 AM revealed she had seen Resident #85's toenails before but she was not sure why he had not been seen by the podiatrist. UM #1 stated one reason might have been the frequent turn-over with the Social Worker position who handled the list of residents seen by the podiatrist. UM #1 stated Resident #85 told her he wanted the podiatrist to see his toenails, so she made sure he was on the list for the 10/17/23 podiatry clinic. An interview with the Director of Nursing (DON) on 10/12/23 at 1:19 PM revealed if a resident was not diabetic, then the nurses or nurse aides could trim toenails unless they needed to be referred to podiatry. The DON stated she was not sure why Resident #85 had not been seen by the podiatrist while he was at the facility.	F 687		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		11/3/23

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F 755	Continued From page 7 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, Pharmacist, Nurse Practitioner, and Medical Director interviews, the facility failed to re-order medications from the pharmacy when there were 5 doses left to ensure medications were available to be administered for 2 of 2 residents (Resident #15 and Resident #35) reviewed for significant medication errors. The findings included: 1. Resident #15 was admitted to the facility on 11/11/22 and readmitted on 02/01/23 with diagnoses which included atrial fibrillation, chronic pain, neuropathy, and muscle spasms.	F 755	1) On 10/12/23, the Director of Nursing (DON) completed a medication error report and audit of active medication orders against actual medications available on the medication cart for Resident #15 and Resident #35 to ensure availability for timely administration as ordered by the physician. All medications will continue to be available for administration as ordered by the physician and refills will be submitted to the pharmacy when five (5) doses are remaining. 2) On 10/26/23 and 10/27/23, the Unit	

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F 755	Continued From page 8 a. A review of Resident #15's physician's orders indicated an active order for Baclofen tablet 20 milligrams (mg) - give 20 mg by mouth 2 times a day at 6:00 AM and 6:00 PM for muscle spasm which started on 04/19/23. Resident #15's Medication Administration Record (MAR) from August to October 2023 indicated the following information. August MAR - on 08/27/23 the Baclofen which was scheduled to be given at 6:00 AM and 6:00 PM was missed for the 6:00 PM dose. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication. September MAR - on 09/23/23 the 6:00 AM and 6:00 PM doses were missed. The medication was marked with a "9" for both doses indicating to see progress notes; however, there were no progress notes on that dated regarding the missed medications. Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 08/27/23 during the 3:00 PM to 11:00 PM shift with no return call received. A phone interview on 10/12/23 at 10:01 AM with Nurse #9 who was an agency nurse revealed she had taken care of Resident #15 on 09/22/23 to 09/23/23 on the 11:00 PM to 7:00 AM shift. Nurse #9 stated she had not given the medication on 09/23/23 because it was not available at the facility. She further stated she called the contracted pharmacy and they told her the	F 755	Managers (UMs) completed an audit of all active facility residents□ active medication orders against actual medication availability on the medication cart. Refills were requested for all residents identified with five (5) doses remaining or less to ensure availability for administration as ordered by the physician. 3) Effective 11/3/23, the Staff Development Coordinator (SDC) provided education to facility and agency licensed nurses and medication aides on ensuring medications are available for administration as ordered by the physician. Education included the process for ordering and reordering when 5 doses or less remain and on process for obtaining medications from contracted pharmacy for routine delivery, urgent (STAT indicating next delivery on same day) and from back-up emergency kit to ensure availability for administration as ordered by the physician. The licensed nurse or medication aide will submit medication refill requests to the pharmacy when five (5) doses remain as noted during routine medication passes. Back-up pharmacy and STAT orders will be utilized when medications are not available in the facility as ordered by the physician. In the event a medication is not available as ordered, the licensed nurse will notify the physician and receive new orders as indicated. The DON and/or UMs will monitor medication cart and medication rooms weekly for timely refills as indicated by five (5) doses remaining and will monitor pharmacy reports on	

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F 755	Continued From page 9 medication had to be re-ordered in the electronic medical record and would be delivered on the next medication delivery to the facility. She stated she was not aware that she needed to re-order the medication when there were 3-5 doses left and was not aware that was the policy of the facility. b. A review of Resident #15's physician's orders indicated an active order for Xarelto tablet 20 mg - give 1 tablet by mouth one time a day for atrial fibrillation - do not substitute which started on 02/02/23. Resident #15's MAR from September to October 2023 indicated the following information: September MAR - On 09/01/23, the MAR indicated the Xarelto which was scheduled to be given at 6:00 AM was not given. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication. October MAR - On 10/08/23 and 10/09/23, the MAR indicated the Xarelto which was scheduled to be given at 6:00 AM was not given. The medication blocks were blank indicating the medications were not given. There were no progress notes on those dates regarding the missed medication. Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 08/31/23 to 09/01/23 on the 11:00 PM to 7:00 AM shift with no return call received. A phone interview on 10/11/23 at 4:26 PM with Nurse #7 revealed she had taken care of	F 755	pharmacy website portal daily to ensure timely pharmacy deliveries to ensure medication availability. 4) The DON will complete an audit of five (5) residents to ensure medications are available for administration as ordered by the physician. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks then, weekly for four (4) weeks. The Administrator will present the results of monitoring to the Quality Assurance Performance Committee monthly and make changes to the plan as necessary to maintain compliance with Pharmacy Services and to ensure residents are free from significant medication errors. Compliance Date: 11/3/23	

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Resident #15 on the 7:00 AM to 3:00 PM shift on 10/08/23 and 10/09/23. Nurse #7 stated she was unable to administer the medication on 10/08/23 and 10/09/23 because it was not available at the facility. She further stated she called the contract pharmacy and was told she had to re-order the medication through the electronic medical record and it would be delivered on the next medication delivery to the facility.

An interview on 10/11/23 at 3:45 PM with the Medical Director (MD) revealed the nurses should reorder medications at least 24 hours in advance before they run out. The MD stated the nurses could call a provider if a script was needed to be sent to the pharmacy for medications even on the weekends.

An interview on 10/12/23 at 1:18 PM with the Director of Nursing (DON) revealed she was not here when these medications were missed for Resident #15 but stated she expected they needed to provide more education to the nurses since most of them were agency nurses about checking in and reordering medications through the EMR.

A phone interview on 10/12/23 at 4:57 PM with the Pharmacist revealed Resident #15's Xarelto was filled on 09/01/23, 09/16/23 and on 10/01/23. She stated the medication was sent in 14-day supplies in plastic baggies. The Pharmacist stated it was possible the 09/01/23 dose did not get to the facility in time to be given if the nurses had not reordered the medication timely but said with the refill on 10/01/23 the medication should have been available to be given on 10/08/23 and 10/09/23.

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An interview on 10/12/23 at 5:10 PM with Unit Manager (UM) #1 revealed the medication was available in the cart for the resident on 10/08/23 and 10/09/23 but the nurse missed it because it was not on a card but in a plastic baggie in between the cards. She stated she would educate the nurses about the medication not being on a card and in baggies instead.

c. A review of Resident #15's physician's orders indicated an active order for Gabapentin Capsule 100 mg - give 1 capsule 3 times a day at 6:00 AM, 12:00 PM and 8:00 PM which was started on 02/01/23.

Resident #15's MAR from September to October 2023 indicated the following information:

September MAR - On 09/28/23 the MAR indicated the Gabapentin which was scheduled at 8:00 PM was not given. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication. On 09/29/23 the MAR indicated the Gabapentin which was scheduled at 2:00 PM was not given. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication.

Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 09/28/23 to 09/29/93 on the 7:00 PM to 7:00 AM shift with no return call.

A phone interview on 10/11/23 at 4:26 PM with Nurse #7 who was an agency nurse revealed she had taken care of Resident #15 on the 3:00 PM to

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11:00 PM shift on 09/23/23 and had not given the resident's Baclofen at 6:00 PM. She also took care of Resident #15 on the 7:00 AM to 3:00 PM shift on 10/08/23 and 10/09/23 and had not administered her Xarelto because it was not available at the facility. Nurse #7 was also assigned to care for Resident #15 on the 7:00 AM to 3:00 PM shift on 09/29/23. Nurse #7 stated she was unable to administer Gabapentin on 09/29/23 because it was not available at the facility. She stated she called the pharmacy and was told she had to re-order the medication through the electronic medical record (EMR) and they would deliver it on the next medication delivery to the facility. Nurse #7 said she was not familiar with the facility's policy for re-ordering medications and was not aware she had to re-order the medication when they were down to 5 remaining doses.

An interview on 10/11/23 at 3:45 PM with the Medical Director (MD) revealed the nurses should reorder medications at least 24 hours in advance before they run out to ensure the medications are received from the pharmacy in time to be administered per the orders. The MD stated the nurses could call a provider if a script was needed to be sent to the pharmacy for medications even on the weekends.

An interview on 10/12/23 at 1:18 PM with the Director of Nursing (DON) revealed she was not here when some of these medications were missed for Resident #15 but was here when the Xarelto was missed and said no one had asked her about how to get the medication for the resident. She stated she expected they needed to provide more education to the nurses about checking in and reordering medications through

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the EMR since most of them were agency nurses. The DON further stated the nurses should be reordering medications through the EMR when there were 5 doses left of the individual medications as indicated in their policy and procedure for re-ordering medications.

2. Resident #35 was admitted to the facility on 12/22/19 with diagnoses that included multiple sclerosis (MS) and chronic pain syndrome.

a. A review of Resident #35's physician's orders indicated an active order for Copaxone 20 milligrams (mg)/milliliters (ml) inject 20 mg subcutaneously one time a day for MS which started on 9/23/22.

Resident #35's Medication Administration Records (MAR) from September to October 2023 indicated the following information:
*September MAR - On 9/3/23 and 9/4/23, the MAR indicated that the Copaxone injection which was scheduled to be given at 8:00 AM was held.
*October MAR - On 10/6/23, the MAR indicated that the Copaxone injection scheduled to be given at 8:00 AM was held and on 10/12/23, the MAR was blank and did not indicate that the Copaxone injection was given to Resident #35.

A phone interview with Nurse #1 on 10/12/23 at 3:15 PM revealed she took care of Resident #35 on day shift on 9/3/23, 9/4/23 and 10/6/23. She was unable to administer Resident #35's Copaxone injection on 9/3/23, 9/4/23 and 10/6/23 because they were not available at the facility. Nurse #1 stated she called back-up pharmacy, but they didn't have it in stock, and she was told that they would deliver it as soon as it became available.

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An interview with Medication Aide (MA) #1 on 10/12/23 at 3:43 PM revealed she was assigned to administer oral medications to Resident #35, but she was not allowed to give her Copaxone injection. MA #1 stated Unit Manager (UM) #1 was supposed to give Resident #35's Copaxone injection but she could not find it and it was not in the refrigerator.

An interview with Unit Manager (UM) #1 on 10/12/23 at 4:13 PM revealed she couldn't give Resident #35's Copaxone injection on 10/12/23 because it was not available. UM #1 stated she called the pharmacy and she found out that they only sent a 5-day supply of the Copaxone injections at a time because of the cost. UM #1 reported that she was surprised about this because they used to send a box of 30 pens at a time and she was unsure when the pharmacy started sending only 5 pens. She further stated that the pharmacy told her that they would send another 5-day supply the next day on 10/13/23. UM #1 further shared that when she talked to Resident #35, Resident #35 reported to her that Nurse #2 knew that she was giving her the last dose of Copaxone injection on 10/11/23 but she didn't re-order it that day.

An interview with Nurse #2 on 10/13/23 at 10:49 AM revealed that she thought she had re-ordered Resident #35's Copaxone injection on 10/11/23 but when she checked the re-order sheet, she couldn't find it. Nurse #2 stated that she must have missed it because she had re-ordered all of Resident #35's other medications but the Copaxone injection was not included in the list.
A phone interview with the Pharmacist on 10/12/23 at 4:39 PM revealed that they currently

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had some Copaxone injectable pens available, and they were sending 5 doses tonight which should be received by the facility on 10/13/23. The Pharmacist stated that they only sent 5 pens of Copaxone injections at a time because of the price and when the facility was down to 2 pens, they should re-order. She stated that they did not receive a request from the facility to re-order Resident #35's Copaxone injection until 10/12/23. She further stated that Resident #35's Copaxone injection was last re-ordered by the facility on 10/6/23 and they sent 5 pens. Before that, they sent a 30-day supply to the facility on 9/3/23 but they switched to a generic kind on 10/6/23 which was more expensive, so they only sent them 5 pens.

A phone interview with the Medical Director on 10/13/23 at 8:52 AM revealed the nurses should re-order Resident #35's Copaxone injections at least 24 hours in advance before they ran out.

An interview with the Director of Nursing (DON) on 10/13/23 at 9:17 AM revealed Resident #35's emergency contact notified her last week that Resident #35 missed her Copaxone injection. The DON stated when she called the pharmacy, they told her that they needed the order for Copaxone injection renewed which was why they couldn't send it. The DON further stated that she tried to find out who the pharmacy relayed this to, but they told her that they sent a fax to the facility, and she didn't know who obtained the fax from the pharmacy. She also stated that she didn't know they only sent 5 injections at a time, and she was trying to negotiate with pharmacy on how they could send at least 30 injections even if the facility had to cover the cost if needed. The DON shared that she encouraged the nurses to

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re-order medications when there were only 5 doses left but with the pharmacy sending only 5 doses at a time, they would need to re-order it more frequently.

b. A review of Resident #35's physician's orders indicated an active order for Fentanyl transdermal patch 72 hour 12 micrograms (mg)/hour - apply one patch transdermally every 72 hours for pain and remove per schedule. This order started on 2/7/23.

Resident #35's Medication Administration Record for August 2023 indicated Resident #35's Fentanyl was applied on 8/23/23 but it was not changed on 8/26/23 as scheduled for 10:00 AM. It was changed on 8/28/23 at 7:00 PM.

An interview with Resident #35 on 10/12/23 at 3:55 PM revealed the she missed a Fentanyl patch change in August because it was not available at the facility.

A phone interview with Nurse #3 on 10/13/23 at 10:25 AM revealed she took care of Resident #35 on 8/26/23 on the day shift but she could not remember the resident and her being out of her Fentanyl patch. Nurse #3 stated if Resident #35 had ran out of her Fentanyl patch, she would have called the pharmacy and re-ordered it or called the doctor to obtain an order to put the medication on hold until it became available.

A phone interview with the Pharmacist on 10/12/23 at 4:39 PM revealed they sent the facility a 30-day supply of Fentanyl patches for Resident #35 on 7/20/23 which would have lasted them until 8/20/23. The Pharmacist stated that the facility should have re-ordered Resident #35's

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Fentanyl patch before 8/20/23 when they were down to 5 patches on hand. This also depended on when the provider wrote a script since they had to write one for each prescription and before they could dispense the Fentanyl patches. The Pharmacist also stated that they did not keep the Fentanyl dose that Resident #35 received in the facility's automated medication dispensing system so they wouldn't have been able to obtain an emergency dose from their stock medications.

A review of a progress note by the Nurse Practitioner (NP) dated 8/28/23 indicated nursing staff reported Resident #35 was out of her Fentanyl patches. A refill was sent in, and one dose was sent electronically to the local pharmacy for staff to pick up. The NP ordered Oxycodone 5 mg by mouth as needed for 4 doses until Fentanyl patch was available.

A phone interview with the Nurse Practitioner (NP) on 10/13/23 at 8:36 AM revealed on 8/28/23, she was informed by the nursing staff that they didn't have any of Resident #35's Fentanyl patches. The NP sent a script to the pharmacy and had them send one dose of Resident #35's Fentanyl patch as soon as possible to the facility. The NP shared that when scripts were needed on a weekend, they had an on-call provider that the nursing staff could call if a narcotic such as Resident #35's Fentanyl patch was needed.

An interview with the Medical Director (MD) on 10/13/23 at 8:52 AM revealed the nurses should re-order medications at least 24 hours in advance before they ran out. The MD stated that the nurses could call a provider if a script was needed to be sent to the pharmacy for narcotic medications even on the weekends.

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F 755	Continued From page 18 An interview with the Director of Nursing (DON) on 10/13/23 at 9:17 AM revealed she received a phone call from Resident #35's emergency contact last week complaining about Resident #35 running out of her Fentanyl patch two months ago. The DON stated she was not aware of what happened and why Resident #35 ran out of her Fentanyl patch.	F 755		
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 medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, Pharmacist, Nurse Practitioner, and Medical Director interviews, the facility failed to administer medications as ordered by the physician that included Xarelto for atrial fibrillation, Baclofen for muscle spasms, Gabapentin for pain, Fentanyl patch for pain and Copaxone injections for Multiple Sclerosis. This occurred for 2 of 2 residents (Resident #15 and Resident #35) reviewed for significant medication errors. The findings included: 1. Resident #15 was admitted to the facility on 11/11/22 and readmitted on 02/01/23 with diagnoses which included atrial fibrillation, chronic pain, seizure disorder, neuropathy, and muscle spasms. Review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated 09/06/23	F 760	1) On 10/12/23, the Director of Nursing (DON) completed a medication error report and audit of active medication orders against actual medications available on the medication cart for Resident #15 and Resident #35 to ensure availability for timely administration as ordered by the physician and to prevent significant medication errors. 2) On 10/30/23, the Director of Nursing (DON) completed an audit of medication administration records (MARs) for all current facility residents from 10/27/23-10/29/23 to ensure residents are free from significant medication errors. Two (2) residents were identified with errors and the DON completed a medication error report accordingly. No harm occurred as a result of findings and no new orders received. Residents will	11/3/23

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F 760	Continued From page 19 revealed she was cognitively intact with no behaviors and required limited to extensive assistance with all activities of daily living. The MDS assessment further revealed Resident #15 received anticoagulant medication 6 out of 7 days during the assessment period. Review of her care plan revised on 09/06/23 revealed a focus area for being on anticoagulant therapy. The interventions included administering anticoagulant medication as ordered by physician and monitor for side effects and effectiveness. Review of the care plan also revealed a focus area for being at risk for alteration in comfort and increased pain related to diagnoses of muscle spasms, history of low back pain, arthritis, and neuropathy. The interventions included administering pain medication as per orders. An interview on 10/09/23 at 11:24 AM with Resident #15 revealed she had missed some medications and most recently had missed 2 days in a row of her Xarelto. She stated she had missed doses of her Gabapentin and her Baclofen and had experienced some increased pain and cramping of her legs because of the missed medication. Resident #15 further stated she was more concerned about her Xarelto because she didn't want to be at risk of having a stroke. a. A review of Resident #15's physician's orders indicated an active order for Baclofen tablet 20 milligrams (mg) - give 20 mg by mouth 2 times a day at 6:00 AM and 6:00 PM for muscle spasm which started on 04/19/23. Resident #15's Medication Administration Record (MAR) from August to October 2023 indicated the	F 760	continue to have medications available for administration as ordered by the physician. 3) Effective 11/3/23, the Staff Development Coordinator (SDC) provided education to facility and agency Licensed Nurses and Medication Aides (MA) on ensuring residents are free from significant medication errors. Education included medication ordering for new medications, reordering process for routine pharmacy delivery when five (5) doses remain, urgent (STAT indicating delivery on same day) and back-up pharmacy process when medications are not readily available and needed, accurate documentation in the medication record and notification to provider when medications unavailable or not administered as ordered and expectation of completing a nursing progress note when medication not given as ordered. (indicated on medication administration record (MAR) with “9” other hold codes or omissions) The DON or Unit Managers (UMs) will review the Medication Administration Audit Report in Point Click Care (PCC electronic medical record) daily to monitor for medication errors and will follow-up to ensure medications continue to be administered as ordered and to provide reeducation or disciplinary action as needed to the licensed nurse or medication aide (MA). Newly hired facility and agency Licensed Nurses and MAs will receive education upon hire and prior to first shift worked.	

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F 760	Continued From page 20 following information. - August MAR - on 08/27/23 that the Baclofen which was scheduled to be given at 6:00 AM and 6:00 PM was missed for the 6:00 PM dose. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication. - September MAR - on 09/23/23 the 6:00 AM and 6:00 PM doses were missed. The medication was marked with a "9" for both doses indicating to see progress notes; however, there were no progress notes on that date regarding the missed medications. Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 08/27/23 during the 3:00 PM to 11:00 PM shift with no return call received. A phone interview on 10/12/23 at 10:01 AM with Nurse #9 revealed she had taken care of Resident #15 on 09/22/23 to 09/23/23 on the 11:00 PM to 7:00 AM shift. Nurse #9 stated if she marked the medication with a "9" that meant the medication was not available to be given. She further stated she did not have access to the locked stock medication system and was not able to check it to see if the medication was available. She indicated when they called the contracted pharmacy, they told her the medication had to be put in the electronic medical record at a certain time (could not remember the time) to get the medications the same day. She further indicated she was not aware of any contract with a local pharmacy they could call to get the medication right away and said the contracted pharmacy had	F 760	4) The DON will audit MARs for accurate, complete documentation of administration of medications as ordered by the physician and for progress notes and follow-up when medications are not available or are not given for any other reason. Monitoring will be completed for five (5) residents at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks then, weekly for four (4) weeks. The Administrator will present the results of monitoring to the Quality Assurance Process Improvement (QAPI) Committee monthly and changes will be made to the plan as necessary to maintain compliance with ensuring residents are free from significant medication errors. Compliance Date: 11/3/23	

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never mentioned a local pharmacy when she had called them.

A phone interview on 10/11/23 at 4:26 PM with Nurse #7 revealed she had taken care of Resident #15 on the 3:00 PM to 11:00 PM shift on 09/23/23. Nurse #7 stated if she marked the medication with a "9" that meant the medication was not available to be given. She further stated she checked the locked stock medication system and the medication was not available. She indicated she called the contracted pharmacy and they told her the medication had to be put in the electronic medication record in time (could not remember what time) to get the medication on the same day. Nurse #7 further indicated she was not aware of the facility having a contract with a local pharmacy or how to get meds from a local pharmacy.

b. A review of Resident #15's physician's orders indicated an active order for Xarelto tablet 20 mg - give 1 tablet by mouth one time a day for atrial fibrillation - do not substitute which started on 02/02/23.

Resident #15's MAR from August to October 2023 indicated the following information:

- September MAR - On 09/01/23, the MAR indicated the Xarelto which was scheduled to be given at 6:00 AM was not given. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication.

- October MAR - On 10/08/23 and 10/09/23, the MAR indicated the Xarelto which was scheduled to be given at 6:00 AM was not given. The

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medication blocks were blank indicating the medications were not given. There were no progress notes on those dates regarding the missed medication.

Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 08/31/23 to 09/01/23 on the 11:00 PM to 7:00 AM shift with no return call received.

A phone interview on 10/11/23 at 4:26 PM with Nurse #7 revealed she had taken care of Resident #15 on the 7:00 AM to 3:00 PM shift on 10/08/23 and 10/09/23. Nurse #7 stated she remembered the medication was not available and was not available in the locked stock medication system so she had called the contracted pharmacy. The contract pharmacy told her the medication had to be put in the electronic medical record in time (could not remember what time) to get the medication on the same day. Nurse #7 further indicated she was not aware of the facility having a contract with a local pharmacy or how to get meds from a local pharmacy.

c. A review of Resident #15's physician's orders indicated an active order for Gabapentin Capsule 100 mg - give 1 capsule 3 times a day at 6:00 AM, 12:00 PM and 8:00 PM which was started on 02/01/23.

Resident #15's MAR from August to October 2023 indicated the following information:

- September MAR - On 09/28/23 the MAR indicated the Gabapentin which was scheduled at 8:00 PM was not given. The medication was marked with a "9" indicating to see progress

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notes; however, there were no progress notes on that date regarding the missed medication. On 09/29/23 the MAR indicated the Gabapentin which was scheduled at 2:00 PM was not given. The medication was marked with a "9" indicating to see progress notes; however, there were no progress notes on that date regarding the missed medication.

Multiple attempts were made to contact the nurse responsible for caring for Resident #15 on 09/28/23 to 09/29/93 on the 7:00 PM to 7:00 AM shift with no return call.

A phone interview on 10/11/23 at 4:26 PM with Nurse #7 revealed she had taken care of Resident #15 on the 7:00 AM to 3:00 PM shift on 09/29/23. Nurse #7 stated if she marked the medication with a "9" that meant the medication was not available to be given. She further stated she checked the locked stock medication system and the medication was not available. She indicated she called the contracted pharmacy and they told her the medication had to be put in the electronic medical record in time (could not remember what time) to get the medication on the same day. Nurse #7 further indicated she was not aware of the facility having a contract with a local pharmacy or how to get meds from a local pharmacy.

An interview on 10/12/23 at 11:26 AM with Unit Manager (UM) #1 revealed she was not aware of Resident #15 missing her Baclofen in August and September 2023, missing her Gabapentin in September 2023 and missing her Xarelto in September and 2 days in a row in October of 2023. She stated the nurses were supposed to reorder medications once they were down to 3-5

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doses of the medication and said they must not have reordered the medication timely. UM #1 further stated they had a backup pharmacy through their main pharmacy which was just up the street from the facility and it should have been filled through them so the resident didn't miss her medication. She indicated it was "bad nursing not to give residents their medications" but when you used agency nurses as much as they did it was difficult to ensure the residents got their medications as ordered.

An interview on 10/11/23 at 3:45 PM with the Medical Director (MD) revealed he was not aware of Resident #15 missing medications and said it should not happen especially given her diagnoses. The MD stated Resident #15 should not miss doses of her Baclofen and Gabapentin and certainly should not miss her Xarelto 2 days in a row; however, it would not be concerning for putting her at risk of a stroke unless she missed the medication for a longer period than 2 days. He further stated she would have to miss the medication more than 20 days to be at risk of a stroke. The MD indicated they had a backup pharmacy that was local and should be contacted for medications that are not available in the facility. He further indicated all the nurses should be aware of the backup pharmacy and how to access medications from them when they are not available through the contracted pharmacy. The MD said he expected to be notified when residents were not receiving medications as ordered and said he had not been notified that Resident #15 had missed these medications. The MD stated he expected all residents to be given their medications as prescribed.

An interview on 10/12/23 at 1:18 PM with the

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Director of Nursing (DON) revealed she was not here when most of these medications were missed for Resident #15 but stated she expected they needed to provide more education to the nurses about administering medications and what they needed to do in the event the medication was not available to be given since most of them were agency nurses. She stated she expected all residents to receive their medications as ordered by the physician.

2. Resident #35 was admitted to the facility on 12/22/19 with diagnoses that included chronic pain syndrome.

Resident #35's care plan revised on 1/23/23 indicated Resident #35 had altered comfort status related to pain. Interventions included to administer pain medications as ordered by the physician and observe for effectiveness.

The quarterly Minimum Data Set (MDS) assessment dated 9/28/23 indicated Resident #35 was cognitively intact, and was totally dependent on staff assistance with all activities of daily living. The MDS further indicated that Resident #35 received an injection and no opioid medication for 7 days during the assessment period.

a. A review of Resident #35's physician's orders indicated an active order for Copaxone 20 milligrams (mg)/milliliters (ml) inject 20 mg subcutaneously one time a day for multiple sclerosis which started on 9/23/22.

Resident #35's Medication Administration Records (MAR) from September to October 2023 indicated the following information:

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*September MAR - On 9/3/23 and 9/4/23, the MAR indicated that the Copaxone injection which was scheduled to be given at 8:00 AM was held. *October MAR - On 10/6/23, the MAR indicated that the Copaxone injection scheduled to be given at 8:00 AM was held and on 10/12/23, the MAR was blank and did not indicate that the Copaxone injection was given to Resident #35.

A phone interview with Nurse #1 on 10/12/23 at 3:15 PM revealed she took care of Resident #35 on day shift on 9/3/23, 9/4/23 and 10/6/23. She was unable to administer Resident #35's Copaxone injection on 9/3/23, 9/4/23 and 10/6/23 because they were not available at the facility. Nurse #1 stated she called back-up pharmacy, but they didn't have it in stock, and she was told that they would deliver it as soon as it became available.

An interview with Resident #35 on 10/12/23 at 3:55 PM revealed she didn't get her Copaxone injection on 10/12/23 because it was not available. Resident #35 stated the staff always blamed the pharmacy or the physician for not filling out the prescription for her medication. Resident #35 reported that the same thing happened a week ago when her Copaxone injection was not given to her because it was not available.

An interview with Medication Aide (MA) #1 on 10/12/23 at 3:43 PM revealed she was assigned to administer oral medications to Resident #35, but she was not allowed to give her Copaxone injection. MA #1 stated Unit Manager (UM) #1 was supposed to give Resident #35's Copaxone injection but she could not find it and it was not in the refrigerator.

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An interview with Unit Manager (UM) #1 on 10/12/23 at 4:13 PM revealed she couldn't give Resident #35's Copaxone injection on 10/12/23 because it was not available. UM #1 stated she called the pharmacy and she found out that they only sent a 5-day supply of the Copaxone injections at a time because of the cost. UM #1 reported that she was surprised about this because they used to send a box of 30 pens at a time and she was unsure when the pharmacy started sending only 5 pens. She further stated that the pharmacy told her that they would send another 5-day supply the next day on 10/13/23. UM #1 further shared that when she talked to Resident #35, Resident #35 reported to her that Nurse #2 knew that she was giving her the last dose of Copaxone injection on 10/11/23 but she didn't re-order it that day.

An interview with Nurse #2 on 10/13/23 at 10:49 AM revealed that she thought she had re-ordered Resident #35's Copaxone injection on 10/11/23 but when she checked the re-order sheet, she couldn't find it. Nurse #2 stated that she must have missed it because she had re-ordered all of Resident #35's other medications but the Copaxone injection was not included in the list. A phone interview with the Medical Director (MD) on 10/13/23 at 8:52 AM revealed he was not aware that Resident #35 had been missing doses of her Copaxone injection. The MD stated that this was not significant but Resident #35 did not need to be missing any doses of her Copaxone injection to keep her in a steady state.

An interview with the Director of Nursing (DON) on 10/13/23 at 9:17 AM revealed Resident #35's emergency contact notified her last week that

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Resident #35 missed her Copaxone injection. The DON stated when she called the pharmacy, they told her that they needed the order for Copaxone injection renewed which was why they couldn't send it. The DON further stated that she tried to find out who the pharmacy relayed this to, but they told her that they sent a fax to the facility, and she didn't know who obtained the fax from the pharmacy. She also stated that she didn't know they only sent 5 injections at a time, and she was trying to negotiate with pharmacy on how they could send at least 30 injections even if the facility had to cover the cost if needed.

b. A review of Resident #35's physician's orders indicated an active order for Fentanyl transdermal patch 72 hour 12 micrograms (mg)/hour - apply one patch transdermally every 72 hours for pain and remove per schedule. This order started on 2/7/23.
Resident #35's Medication Administration Record for August 2023 indicated Resident #35's Fentanyl was applied on 8/23/23 but it was not changed on 8/26/23 as scheduled for 10:00 AM. It was changed on 8/28/23 at 7:00 PM.

An interview with Resident #35 on 10/12/23 at 3:55 PM revealed the she missed a Fentanyl patch change in August because it was not available at the facility.

A phone interview with Nurse #3 on 10/13/23 at 10:25 AM revealed she took care of Resident #35 on 8/26/23 on the day shift but she could not remember the resident and her being out of her Fentanyl patch. Nurse #3 stated if Resident #35 had ran out of her Fentanyl patch, she would have called the pharmacy and re-ordered it or called the doctor to obtain an order to put the

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medication on hold until it became available.

A review of a progress note by the Nurse Practitioner (NP) dated 8/28/23 indicated nursing staff reported Resident #35 was out of her Fentanyl patches. A refill was sent in, and one dose was sent electronically to the local pharmacy for staff to pick up. The NP ordered Oxycodone 5 mg by mouth as needed for 4 doses until the Fentanyl patch was available. The NP progress note further indicated the NP assessed Resident #35's pain during the visit and Resident #35 complained of chronic intermittent pain to the lower back and rated her pain level at 6 out of 10 (with 1 being minimal pain and 10 being severe pain). Resident #35 reported her pain was alleviated by repositioning and rest.

A phone interview with the Nurse Practitioner (NP) on 10/13/23 at 8:36 AM revealed on 8/28/23, she was informed by the nursing staff that they didn't have any of Resident #35's Fentanyl patches. The NP sent a script to the pharmacy and had them send one dose of Resident #35's Fentanyl patch as soon as possible to the facility. The NP stated she also ordered an alternate pain medication which was Oxycodone to be given by the nurses as needed until the Fentanyl patch became available. The NP also stated that when she assessed Resident #35 on 8/26/23, she complained of generalized pain, but it was not severe, and she did not note any signs of withdrawal. The NP shared that when scripts were needed on a weekend, they had an on-call provider that the nursing staff could call if a narcotic such as Resident #35's Fentanyl patch was needed.

A phone interview with the Medical Director (MD)

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F 760	Continued From page 30 on 10/13/23 at 8:52 AM revealed it was not significant that Resident #35 missed a dose of her Fentanyl patch as long as it was substituted with something else to keep her pain controlled. However, the MD stated that he expected Resident #35's medications to be given as ordered and as prescribed by him. An interview with the Director of Nursing (DON) on 10/13/23 at 9:17 AM revealed she received a phone call from Resident #35's emergency contact last week complaining about Resident #35 running out of her Fentanyl patch two months ago. The DON stated she was not aware of what happened and why Resident #35 ran out of her Fentanyl patch.	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	F 761		11/3/23

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F 761	Continued From page 31 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to store unopened medications in the temperatures specified by manufacturer's guidelines for 1 or 4 medications carts observed during medication storage checks (A hall medication cart #2). The findings included: Review of facility's medication storage policy and procedure dated 11/01/20 indicated all medications in the facility would be stored in the medication rooms or medication carts according to the manufacturer's recommendations to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of manufacturer's package insert for Latanoprost eye drops reveled unopened bottle should be stored under refrigeration between 36° to 46° Fahrenheit (F) and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77° F for up to six weeks. Review of manufacturer's package insert for insulin glargine injection indicated unopened pen should be stored in refrigerator at 36°F to 46°F until expiration and kept away from direct heat and light. Once the insulin was opened, it could be stored at room temperature (below 86°F) or	F 761	1) The facility failed to maintain proper medication storage when an insulin pen and eyes drops were removed from refrigerator and stored on A-Hall medication cart prior to being opened. On 10/12/23 upon identification, the Unit Manager (UM) removed the improperly stored medications and disposed of them as indicated and reordered medications accordingly. 2) All current facility residents are at risk of being affected by this deficient practice. On 10/20/23, the Unit Managers (UMs)audited all facility medication carts and rooms for proper storage. No further improperly stored medications were identified. 3) Effective 11/3/23, the staff development coordinator (SDC) completed education with facility and agency licensed nurses and certified medication aides on the Medication and Biological Storage policy. Education included the proper storage of medications as indicated by the manufacturer, ensuring medications requiring refrigeration are properly stored until opened for use, and proper labeling	

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F 761	Continued From page 32 under refrigeration for up to 28 days. An observation was conducted on 10/11/23 at 4:20 PM for medication cart #2 in A hall in the presence of Nurse #12. The observation revealed one unopened, undated pen of insulin glargine with manufacturer's expiration date of March 2025, and one unopened, undated bottle of Latanoprost 0.005% eye drop wrapped in the plastic seal with manufacturer's expiration date of June 2025. Both medications were stored at room temperature in the medication cart and ready to be used. An interview was conducted with Nurse #12 on 10/11/23 at 4:24 PM. She stated she checked the medication cart after she had started her shift this morning but could not recall seeing the unopened insulin pen and Latanoprost eye drop in the medication cart at that time. She did not know who had put the unopened insulin pen and the unopened Latanoprost eye drop in the medication cart. She added the unopened insulin pen and eye drop should be stored in the refrigerator until they were ready to be used. During an interview conducted on 10/11/23 at 4:33 PM, Unit Manager #2 confirmed that she was the one who had pulled the insulin glargine and Latanoprost eye drop from the refrigerator and put them in the medication cart #2 in A hall as both medications were run out in the medication cart. She acknowledged that she had forgotten that both medications should be stored in the refrigerator until they were ready to be used. An interview was conducted with the Director of Nursing (DON) on 10/12/23 at 9:06 AM. She stated the unopened insulin pen and Latanoprost	F 761	and dating of multi-dose medications when opened and proper destruction of medications prior to expiration. A Medication Storage Guide is available at each nurse□s station and each medication room for quick reference. Newly hired agency and facility licensed nurses and certified medication aides will be educated upon hire and prior to working their next shift. 4) The UMs will audit all medication carts and rooms to ensure proper storage. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks then, weekly for four (4) weeks. The Administrator will present the results of monitoring to the Quality Assurance Performance improvement Committee monthly and makes changes to the plan as necessary to maintain compliance with proper storage of medications and biologicals. 5) Compliance Date: 11/3/23	

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F 761	Continued From page 33 eye drop should be stored in the refrigerator until it was ready to be used. Once it had opened, it had to be dated with opening date and expiration date. It was her expectation for all the nursing staff to follow the facility's medication storage policy and procedure to ensure all the medications being stored as specified by the manufacturer. During an interview conducted on 10/12/23 at 10:43 AM, the Administrator expected nursing staff to follow the facility's medication storage policy & procedure to ensure all the medications being stored as specified by the manufacturer.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		11/3/23

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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 791	Continued From page 34 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to obtain dental services needed for extractions for 1 of 2 resident's reviewed for dental services (Resident #62). The Findings Included: Resident #62 was admitted to the facility on 9/11/2021 with diagnosis that included congestive heart failure and kidney disease. The annual Minimal Data Set (MDS) dated 7/3/23 coded Resident #62 as cognitively intact and with no dental concerns. A review of Resident #62's dental records	F 791	1) On 10/10/23, the Unit Manager (UM) offered Resident #62 emergency dental services for new dentures but, resident declined and denies current dental concerns or oral pain. Resident #62 consented to routine dental services and was seen during the dental clinic on 10/17/23. No new orders received, and care plan updated to reflect dental status and resident preference to refuse dentures and maintain own natural teeth. 2) On 10/31/23, licensed nurses completed oral assessments on all current facility residents. The Physician was notified of residents identified with dental concerns requiring emergency	

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F 791	Continued From page 35 revealed Resident #62 last received dental service on 10/7/22 and a dental consent for tooth extractions was signed on 10/21/22 by Resident # 62 and a Nurse Practitioner. A review of Resident #62's medical record and progress notes revealed no additional dental exams or dental notes after the signed consent on 10/22/23. On 10/09/23 at 2:10 PM Resident # 62 stated he had been waiting 6 months to receive his upper dentures. Resident #62 said during his last dental exam, he agreed to have his remaining upper teeth pulled so he could receive upper dentures and a consent was signed by him. He stated he had not been seen by the dentist or had his teeth extracted. Resident #62 stated he did not have any mouth or tooth pain and was able to eat fine and could wait to receive his dentures. The Dental Hygienist was in the facility providing dental services and stated on 10/10/23 at 11:23 AM Resident #62 had not been seen by her or the Dentist since October of 2022. The Dental Hygienist verified Resident #62 was not on her list to be seen. The Social Worker (SW) stated in an interview on 10/10/23 at 12:54 PM Resident #62 was not seen by the dental clinic on 9/28/23 and was not on the list to be seen on 10/10/23. She stated that residents were seen by the dental clinic every 150 days. The SW stated she was not working at the facility in 2022 and was unaware Resident #62 needed to have tooth extractions for upper dentures, he had not told her he had any dental concerns or wanted dentures. The SW stated she would contact the dental clinic and find out if	F 791	dental care such as broken, missing or caried teeth or missing/ill-fitting dentures that cause oral pain and nutritional concerns. The Social Worker submitted referrals for emergency dental care within three (3) days of assessed concerns. 3) Effective 11/3/23, the Staff Development Coordinator (SDC) provided education to current facility and agency licensed nurses, nurse aides and Social Workers on dental service requirements for facility residents. Education included completion of oral assessments by the licensed nurse upon admission, annually and as needed and reporting dental concerns to the Physician. The role of nurse aide is to provide oral care during morning and evening activities of daily living (ADL) and report dental concerns to the licensed nurse if concerns observed or reported such as sore, bleeding gums, missing or ill-fitting dentures, difficulty eating or complaints of oral pain. The licensed nurse will notify the Social Worker of emergent dental referrals who will then coordinate emergency services within three (3) days of concern being assessed and will also maintain routine dental appointments annually and dental hygienist appointments bi-annually as consented by the resident. A dental log will be maintained by the Social Worker for monitoring purposes. Newly hired facility and agency licensed nurses, nurse aides and Social Workers will receive education upon hire and prior to next shift worked.	

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F 791	Continued From page 36 Resident #62 would need to be added to the list or be sent out to a dentist. The Dentist was able to do teeth extractions in the facility. The SW stated when she spoke to residents who were cognitively intact, she relied on them to tell her if they needed any dental service. If a resident said they had concerns with their teeth, she would add them to the dental visit list for the dental hygienist or dentist to see them and sent the list to the dental provider. The Administrator stated on 10/12/23 at 1:54 PM that Resident # 62 should have had his teeth extracted for dentures when the consent was signed in October of last year.	F 791	4) The Minimum Data Set (MDS) nurse will make observations of five (5) residents to ensure appropriate routine and emergency dental care is provided. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks. The Administrator will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with dental services. 5) Compliance date: 11/3/23	
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	F 812		11/3/23

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F 812	Continued From page 37 by: Based on observations and interviews with staff, the facility failed to clean 2 of 2 ice scoop holders and failed to store an ice scoop under sanitary conditions. This practice had the potential to affect beverages served to residents. The findings included: An observation of the A Hall ice chest cooler ice scoop holder on 10/11/23 at 9:44 AM revealed standing water with grey/brown debris in the water in the bottom of the ice scoop holder. The tip of the ice scoop was submerged in the water. An interview with NA #2 on 10/11/23 at 9:44 AM said the coolers and ice scoops were cleaned by the kitchen but was unable to recall when ice chest and scoops were cleaned. An observation of the B Hall ice chest cooler and ice scoop holder on 10/11/23 at 10:05 AM revealed grey/brown debris in the bottom of the ice scoop holder with standing water. The standing water was not touching the ice scoop. The Dietary Manager (DM) stated on 10/11/23 at 10:39 AM the ice chest and ice scoops were not the responsibility of the kitchen to be checked for cleanliness and to be cleaned. The DM stated he was unaware of a cleaning schedule for the ice chest and coolers to be cleaned. The Director of Nursing (DON) stated on 10/12/23 at 1:14 PM the ice scoops, holder and chest should be cleaned as needed by the kitchen. The Administrator stated on 10/12/23 at 1:54 PM the ice chest, scoops and scoop holders should	F 812	1) On 10/11/23, the Dietary Manager (DM) removed and replaced the ice coolers and ice scoops on A-Hall and B-Hall after being properly cleaned and sanitized through the dish washer. 2) On 10/11/23, the DM and Administrator audited all ice scoops, scoop holders and ice chests and each were sanitized through the dishwashing machine to ensure proper sanitation and no free-standing water or debris. On 11/1/23, the facility received new ice scoop holders and ice chests that are equipped with a draining system to ensure sanitary storage to prevent the potential to affect beverages served to residents. 3) On 10/23/23, the Administrator provided education to dietary staff on proper food procurement, store/prepare/serve-sanitary to include the process of ensuring residents are served beverages under sanitary conditions. Education included daily sanitation of ice chests, ice scoops and scoop holders and documentation on the daily Ice Sanitation Log and completion of daily and weekly sanitation audits. Effective 11/3/23, the staff development coordinator (SDC) provided education to facility and agency licensed nurses (LNs), medication aides (MAs), nurse aides (NAs), patient care assistants (PCAs) and dietary staff on maintaining sanitary conditions for beverages served to residents. The nursing staff will be responsible for bringing all ice chests and ice scoops and	

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F 812	Continued From page 38 be cleaned regularly and as needed by the kitchen staff.	F 812	scoop holders to the kitchen daily for proper sanitation through the dishwasher and for replacing them with clean, sanitized ice containers. Education included the expectation of visually inspecting ice containers and scoops for presence of debris or freestanding water and refraining from serving ice under unsanitary conditions. Newly hired facility and agency LNs, MAs, NAs, PCAs and dietary staff will receive education upon hire and prior to first work shift. 4) The Administrator will audit all facility ice scoops, scoop holders and ice containers to ensure proper sanitation of beverages served to residents. Monitoring will be completed at a frequency of three (3) times weekly for four (4) weeks then, two (2) times weekly for four (4) weeks then, weekly for four (4) weeks. The Administrator will present the results of monitoring to the Quality Assurance Performance Improvement Committee monthly and makes changes to the plan as necessary to maintain compliance with food procurement, store/prepare/serve-sanitary. 5) Compliance Date: 11/3/23	
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		11/3/23

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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 41 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, resident and staff interviews and record review, the facility's Quality Assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint surveys dated 07/11/22 and 07/23/21 to achieve and sustain compliance. This was for 1 recited deficiency on the current recertification and complaint investigation survey of 10/13/23 related to food procurement, store/prepare/serve-sanitary. The continued	F 867	1) On 10/12/23, the Dietary Manager removed and replaced the ice coolers and ice scoops on A-Hall and B-Hall after being properly cleaned and sanitized through the dish washer. 2) On 10/16/23, an Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by Administrator with QAPI committee members to determine the root cause of	

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F 867	Continued From page 42 failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F-812 - Based on observations and interviews with staff, the facility failed to clean 2 of 2 ice scoop holders and failed to store an ice scoop under sanitary conditions. This practice had the potential to affect beverages served to residents. During the previous recertification and complaint survey on 07/11/22, the facility failed to change oil used in a deep fryer that appeared burnt and black in color, failed to remove a buildup of dark colored oil splatter marks from the inside and outside of the fryer and from the shelves of metal table located beside the fryer, failed to remove crumbs and dust debris from the lower shelf of a metal prep table, failed to remove a buildup of a black colored substance from two ceiling vents located above the steam table to prevent possible cross contamination of food, and failed to ensure staff covered facial hair during food service and meal tray setup. These failures had the potential to affect the food being served to residents. During the previous recertification and complaint survey on 07/23/21, the facility failed to remove expired food from 1 of 1 walk-in coolers, failed to date nutritional supplements to identify their use by date, failed to maintain a sanitary milk cooler and failed to ensure the milk cooler was free of standing water for 1 of 1 milk cooler, failed to maintain a sanitary reach-in cooler for 1 of 1 reach-in cooler, failed to maintain a sanitary ice	F 867	the facilities failure to implement, monitor, revise as needed the action plan developed for the recertification and complaint surveys dated 7/11/22 and 7/23/21 to achieve and sustain compliance for F812 related to food procurement, store/prepare/serve-sanitary. Root cause determined that the facility did not have an effective monitoring system in place that ensured the dietary department was completing routine, sanitation audits of food services to maintain proper sanitation practices which led to previous citations and the current citation identified during a recertification and complaint survey on 10/12/23. 3) On 10/16/23, the VP of Clinical and QAPI provided education to the QAPI committee on the facility QAPI Policy and F867 regulation which outline the expectations of maintaining an effective quality assurance program and monitoring system to maintain performance improvement plans to ensure ongoing compliance of identified deficient practice. Beginning 11/3/23, the facility QAPI committee will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools for repeat citation F812 related to food procurement, store/prepare/serve-sanitary to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained per corrective plan. 4) The Vice President of Clinical and Quality assessment performance	

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F 867	Continued From page 43 machine for 1 of 1 ice machine, failed to maintain sanitary nourishment room refrigerators for 2 of 2 nourishment refrigerators (200 hall nourishment refrigerator and 300 hall nourishment refrigerator), and failed to ensure food and beverages were labeled and dated for 2 of 2 nourishment refrigerators and freezers. An interview was conducted with the Administrator on 09/28/23 at 11:26 AM. He stated he rounded the facility on a regular basis to identify potential issues and to address the findings proactively. The facility held QA meetings almost daily and had done Quality Assurance and Performance Improvement (QAPI) process per the facility's protocol so far. He explained he had just started his role as the Administrator in late August and was not in the facility long enough to provide any pertinent information to explain why food storage/sanitary was cited repeatedly.	F 867	improvement or Regional Director of Operations will attend QAPI meetings once monthly for three (3) months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations by reviewing weekly QAPI meeting minutes and monitoring tools and will make recommendations to the facility QAPI committee as appropriate to maintain compliance with QA improvement activities for F812 related to food procurement, store/prepare/serve-sanitary. 5) Compliance Date: 11/3/23	