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	345490	A. BUILDING ______ B. WING ______	C 11/16/2023

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AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

(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 were conducted on 11/12/23 through 11/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #01SI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/12/23-11/16/23. Event ID# 01SI11. The following intakes were investigated: NC00208782, NC00208709, NC00209657, NC00202415, NC00201585, NC00199671, NC00202588 and NC00203971. 7 of the 28 allegations resulted in deficiency.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		12/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/13/2023

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 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record reviews, the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 2 of 3 residents (Resident #46 and Resident #125) reviewed for participation in care plans. The findings included: 1. Resident #46 was admitted to the facility on 2/4/21. Diagnosis included, in part, chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated 9/29/23 revealed Resident #46 had intact cognition. Resident #46's medical record was reviewed and revealed the comprehensive care plan had been updated on 1/20/23, 4/7/23, 5/5/23 and 7/5/23. During an interview with Resident #46 on 11/14/23 at 2:02 PM, she stated she had not been invited to care plan meetings but would like to be	F 553	On 11/14/23, the social worker scheduled a care plan meeting with resident #46. The care plan meeting was held with the resident in attendance on 11/15/23. Resident #125 no longer resides in the facility. Resident had planned discharge on 11/29/23 prior to care plan meeting being established. Discharge instructions reviewed at the time of discharge. Care plans mailed to resident and resident representative. Director of Nursing or Social Service will follow up with resident by 12/18/2023. On 12/11/23, the Medical Records Director and/or Quality Assurance Nurse (QA) initiated an audit of all newly admitted residents from 11/1/23 to 12/10/23 to ensure a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided a written invitation to the care plan meeting with documentation in the electronic record. The Medical Records Director	

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F 553	Continued From page 2 included in the development of her care plan and participate in the process. The medical record demonstrated no evidence Resident #46 had been invited to care plan meetings. MDS Nurse #1 was interviewed on 11/14/23 at 10:29 AM. She stated that each month, she printed a list of residents who were scheduled for a care plan review and gave the list to the Social Worker (SW). MDS Nurse #1 did not know how the SW invited residents and families to care plan meetings and was unsure if Resident #46 had been invited to her care plan meetings. On 11/14/23 at 1:50 PM, an interview was conducted with the SW. She explained MDS Nurse #1 gave her a list of residents who were due to be reviewed in care plan meetings. The SW called and invited families a few days before the scheduled meeting. She also invited residents to participate in the care plan meeting. The SW shared she had worked at the facility since January 2023 but had not met with Resident #46 and reviewed her care plan, nor had the facility invited the resident to participate in a care plan meeting. The SW added it was her responsibility to schedule care plan meetings with residents and families and said, "I've just not been consistent with it." An interview was conducted with Mobile Administrator #1 and Mobile Administrator #2 on 11/14/23 at 4:38 PM. Mobile Administrator #2, who had been at the facility for a few weeks, explained he typically asked during the department head morning meeting if there were any care plan meetings scheduled for the day.	F 553	and/or QA nurse will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting for any resident or resident representative who was not provided a written invitation per facility protocol or have written documentation of attending/declining to attend care plan meeting. The audit will be completed by 12/22/23. On 12/11/23, the nurse consultant initiated an audit of residents most recent care plan meeting held from 11/1/23-12/10/23 to ensure the resident and/or resident representative was provided a written invitation to the care plan meeting with documentation in the electronic record. The MDS nurses and/or Social Worker will schedule a care plan meeting for any resident or resident representative who was not provided a written invitation per facility protocol or have written documentation of attending/declining to attend care plan meeting. The audit will be completed by 12/22/23. On 12/11/23, the QA nurse initiated an in-service with the administrator, director of nursing (DON), Medical Directors, MDS nurses and social worker regarding Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) timely scheduling of care plan meetings following admission, with changes in plan of care and/or quarterly and (3) providing the resident and/or resident representative a written invitation to care plan meeting with documentation in the electronic record. The in-service will be completed by 12/22/23.	

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He shared the SW was responsible to invite residents to care plan meetings. Mobile Administrator #1 said she worked at the facility from April through June 2023. She stated she wasn't "necessarily asking the SW who she had coming to care plan or who she had invited." During her time at the facility, Mobile Administrator #1 said she had not confirmed with the SW if she had been inviting the residents to their care plan meeting but had only asked who was scheduled for care plans.

2. Resident #125 was admitted to the facility on 10/6/2023. Resident #125 was discharged on 10/13/2023 to the hospital and was re-admitted to the facility on 10/23/2023. His diagnoses included a lower respiratory infection.

The most recent 5-day Minimum Data Set (MDS) assessment dated 10/29/2023 indicated Resident #125 was cognitively intact and independent in performing his activities of daily living.

A care plan was initiated for Resident #125 on 10/06/2023 and additional focuses were added to the care plan on 10/13/2023. A revision to Resident #125's care plan was made on 11/15/2023 related to his code status.

On 11/12/2023 at 2:29 p.m., an interview was conducted with Resident #125, and Resident #125's spouse was present. Both Resident #125 and Resident #125's spouse (who reported she was staying with Resident #125 around the clock/24 -hours during his admission to the facility) stated a care plan meeting with interdisciplinary members of the staff to discuss his care had not been scheduled or conducted with Resident #125 or Resident #125's wife since his admission to the facility.

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The MDS nurses will audit 10% of newly held care plan meetings to include resident #46 and newly admitted/re-admitted residents weekly x 4 weeks then monthly x 1 month to ensure a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided a written invitation to the care plan meeting with documentation in the electronic record.
The MDS nurses, Social Worker, and/or Medical Records Director will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting per facility guidelines, providing a written invitation to the resident and/or resident representative with documentation in the electronic record and/or re-education of staff. The Administrator will review the care plan audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.
The Quality Assurance nurse will forward the results of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 553	Continued From page 4 On 11/15/2023 at 10:16 a.m. in an interview with Social Worker #1, she stated she was responsible for scheduling care plan meetings for residents within 14 days of admission to the facility. She stated she was not aware of Resident #125 having a care plan meeting since his admission. She explained Resident #125 was admitted while she was on a leave for absence, and she was unsure who was responsible for the care plan meeting while she was on leave. She further stated since returning to work one week ago, she had not scheduled a care plan meeting for Resident #125. On 11/15/23 at 3:24 p.m. in a phone interview with the former Administrator #3, she stated while Social Worker #1 was on leave, she assumed the responsibilities of the Social Services Department. She explained discharges and home health referrals were the priority, and she attempted to conduct care plan meetings with new admissions. She stated care plan meetings needed to be held on admission and quarterly. She said she didn't know why Resident #125's care plan meeting was not held and explained she was also out of work herself due to illness during the first part of October 2023. On 11/16/2023 at 2:45 p.m. in an interview with Mobile Administrator #1, she stated a care plan meeting should be held within twenty-one days of admission and quarterly afterwards. She explained the social worker had been out on leave, and former Administrator #3 assumed the responsibilities of scheduling care plan meetings.	F 553		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		12/22/23

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F 578	Continued From page 5 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview and staff interviews, the facility failed to ensure a resident's code status was accurately recorded on the electronic and paper medical record for 1 of 18 residents reviewed for advance directives (Resident #125).

Findings included:

Resident #125 was admitted to the facility on 10/6/2023. Resident #125 was discharged on 10/13/2023 to the hospital and was re-admitted to the facility on 10/23/2023.

A discontinued physician order on the electronic medical record (EMR) dated 10/6/2023 indicated Resident #125 was a full code (attempt resuscitation). There was no physician order for Resident #125's code status since his re-admission on 10/23/2023.

The discharge summary from the hospital dated 10/23/2023 reported Resident #125's code status as a Do Not Resuscitate (DNR).

A physician's progress note dated 10/24/2023 indicated Resident #125's code status was a full code.

There was no code status indicated on Resident #125's profile on the electronic medical record (EMR).

There was no Do Not Resuscitate form in Resident #125's paper medical record.

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Resident #125 no longer resides in the facility. On 11/15/23 the social worker reviewed with Resident #125 the right to accept or refuse medical or surgical treatment and formulate an advanced directive. Resident was provided written information on advanced directives and elected to be a Do Not Resuscitate. The physician was notified, and the electronic health updated.
On 12/11/23, the Medical Records Director initiated an audit of all resident orders for advance directive/code status. This audit is to ensure the Social Worker and/or nurse reviewed with the resident and/or resident representative the desired advance directive/code status, the physician was notified of desired advance directive/code status, an order placed in the electronic record, the care plan updated to reflect resident desired advance directive/code status when indicated and a golden rod advance directive form was placed in the resident chart for any resident identified as requesting “Do Not Resuscitate”. The Social Worker and/or nurse will address all concerns identified during the audit to include notification of the physician of desired advance directive/code status and updating electronic record when indicated. The audit will be completed by 12/22/23.
On 12/11/23, the Administrator initiated an in-service with the Social Worker, Admission Director, and Director of

F 578 Continued From page 7

The 5-day admission Minimum Data Set (MDS) assessment dated 10/29/2023 indicated Resident #125 was cognitively intact.

On 11/15/23 at 8:05 a.m. in an interview with Resident #125, he explained a code status of DNR was decided when he was at the hospital. He stated he had not signed papers indicating his code status was a DNR since admission to the facility and was willing to sign forms for a code status of DNR.

On 11/15/23 at 8:06 a.m. in an interview with Nurse #1, she stated Resident #125's code status was on the EMR. After reviewing the EMR, Nurse #1 stated Resident 125's code status and a physician order for Resident #125's code status was not in the EMR. When Nurse #1 checked the paper medical record located at nurse's station #3, there was no signed DNR form in Resident #125's paper medical record. Nurse #1 stated based on the white name label on the paper medical record, Resident #125's code status was a full code currently. She explained blue name labels identified a resident's code status as a DNR. She stated Social Worker #1 was responsible for discussing code status with residents after admission to the facility.

On 11/15/2023 at 9:00 a.m. in a follow- up interview with Resident #125, he stated he did not recall anyone asking him on admission to the facility about his code status and had not told anyone at the facility he wanted to be a full code. He stated if anyone would have asked, he would had told them he was a no code because it was decided at the hospital.

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Nursing regarding Advance Directives with emphasis on ensuring the assigned hall nurse and social worker reviews advance directives with the resident and/or resident representative upon admission/ readmission, notify the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic record/care plan and ensuring a golden rod advance directive form was placed in the resident chart for any resident identified as requesting “Do Not Resuscitate”. The in-service will be completed by 12/22/23. After 12/22/23, any Social Worker, Admission Director or Director of Nursing who has not completed the in-service will complete upon the next scheduled work shift. All newly hired social workers, admission director and/or Director of Nursing will be in-service during orientation regarding Advance Directives. On 12/11/23, the Director of Nursing and/or Quality Assurance nurse (QA) initiated an in-service with all nurses regarding Advance Directives with emphasis on the assigned hall nurse reviewing advance directives with the resident and/or resident representative upon admission, notification of the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic record/care plan, and ensuring a golden rod advance directive form in placed in the resident chart when indicated. In-service will be completed by 12/22/23. After 12/22/23 any nurse who has not received the in-service will be in-service

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On 11/15/2023 at 9:47 a.m. in a further interview with Resident #125, he said Social Worker #1 came to his room to discuss his code status after the interview at 8:05 a.m. on 11/15/23. He explained he informed Social Worker #1 his wish for cardiopulmonary resuscitation (CPR) not to be performed, and she provided him some documents to sign. Resident #125 said he was currently working with Social Worker #1 in signing some forms for a code status of DNR.

On 11/15/23 at 10:20 a.m. in an interview with Social Worker #1, she stated she was responsible for initially addressing residents' code status when residents were admitted to the facility, and when a resident requested a change in code status. She explained Resident #125's initial admission statement conducted in the admission office on admission indicated Resident #125's code status was a full code. She stated she went to discuss code status with Resident #125 after Nurse #1 informed her there was no code status on Resident #125's EMR or paper medical record and per a request of the Director of Nursing. She explained she did not set the code status on the EMR and was currently working with Resident #125 to prepare his DNR documents.

On 11/15/23 at 10:42 a.m. in an interview with Admission Office Staff, he explained he was responsible for asking residents on admission about code status: DNR or full code. He stated by default, the resident's code status would be a full code if there was no documentation of a DNR code status, and residents were asked to sign a code status statement when the resident requested a code status of DNR. He stated he did not have access to Resident #125's hospital

F 578

upon the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Advance Directives.
The Medical Records Director and Quality Assurance Nurse (QA) will review all admissions/readmissions during Interdisciplinary Team Meeting (IDT) 5 times a week x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to ensure that the Social Worker, Admission Director and/or nurse reviewed advance directive/code status with the resident and/or resident representative upon admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and that the care plan was updated to reflect resident desired advance directive/code status.
The Medical Records Director and/or Quality Assurance Nurse will address all concerns identified during the audit to include reviewing resident /resident representative preference for advance directive, obtaining order when indicated and updating resident chart for desired advance directive status. The Director of Nursing will review the Advance Directive Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed.
The QA nurse will forward the results of the Advance Directive Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to

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F 578	Continued From page 9 discharge summary for code status information, only nurses and the physician had access. He explained at the direction of an unnamed former Administrator, he was responsible for entering an order for residents' code status on admission and recalled Resident #125 requested to be a full code on the 10/6/2023 admission. The Admission Office Staff stated when Resident #125 was re-admitted to the facility on 10/23/2023, Resident #125 stated he wanted to remain a code status of full code. The Admission Office Staff explained the reason Resident #125's EMR did not show a current code status was because he did not realize when Resident #125 was discharged from the facility on 10/13/2023 and was re-admitted to the facility on 10/23/2023, a code status order had to be re-entered into the EMR. On 11/16/2023 at 1:53 p.m. in an interview with the Director of Nursing, he explained identifying a resident's code status was included on the admission check list. He stated after confirming Resident #125's code status, the nurse re-admitting Resident #125 on 10/23/2023 should have entered an order for Resident #125's code status, not the Admission Office Staff. On 11/16/2023 at 2:45 p.m. in an interview with the Administrator #1, she explained as part of the admission process to the facility, the interdisciplinary team (IDT) discussed residents' code status and was responsible for ensuring resident's code status had been entered in the EMR correctly. She stated she did not know why the IDT did not identify after Resident #125's re-admission on 10/23/2023 there was no code status on the EMR and clarify Resident #125's code status since there was no physician order.	F 578	determine the need for further and / or frequency of monitoring.	

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F 641	Continued From page 10	F 641		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for residents receiving Aspirin (an antiplatelet that prevents blood cells clumping together to form a clot) for 2 of 18 residents reviewed for MDS accuracy (Resident #30 and Resident #68). Findings included: 1. Resident #30 was admitted to the facility on 11/2/2022, and diagnoses included stroke. Physician orders dated 11/2/2022 included Chewable Aspirin 81 milligrams (mg) daily for cardiovascular disease. The October and November 2023 Medication Administration Records (MAR) recorded Resident #30 received Chewable Aspirin 81mg daily from 10/1/2023 to 10/31/2023 and from 11/1/2023 to 11/07/2023. The annual Minimum Data Set (MDS) assessment dated 11/7/2023 indicated Resident #30 was moderately cognitively impaired and was not receiving antiplatelets. In an interview with MDS Nurse #1 on 11/16/2023 at 9:24 a.m., she stated based on training for the new MDS guidelines for October 2023, not all	F 641	On 11/16/23, The Minimum Data Set Coordinator (MDS) completed a modification to prior comprehensive assessment for resident # 30 and resident #68 to reflect accurate coding for use of antiplatelets in section N. On 11/21/23, the MDS consultant completed an audit of all comprehensive assessment section N from 10/1/23 to 11/16/23 include resident #30 and resident #68 to ensure all MDS assessments completed are coded accurately for use of antiplatelets. The MDS completed modifications for all concerns identified during the audit. On 12/4/23, the MDS Consultant completed an in-service with the MDS Coordinator and MDS nurse regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely to include use of antiplatelets. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation regarding MDS Assessments and Coding. The Director of Nursing and/or Quality Assurance Nurse will audit 10% of newly completed MDS assessments section “N” weekly x 4 weeks then monthly x 1 month	12/22/23

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Aspirin medications were coded as an antiplatelet, only Aspirin Delayed Release. She explained because Resident #30 was receiving Chewable Aspirin and not Aspirin Delayed Release, the MDS assessment was not coded for an antiplatelet. In a follow-up interview with Nurse #1 on 11/16/2023 at 10:05 a.m., she stated she had spoken to her MDS Consultant, and the information on coding Aspirin received in the MDS training was incorrect. She said all Aspirin medications were to be coded an antiplatelets, and Resident #30's MDS should have been coded for antiplatelets.

In an interview with Director of Nursing on 11/16/2023 at 1:53 p.m., he stated Resident #30's MDS assessment should have been coded accurately for the use of Aspirin, and he did not know if Aspirin was an anticoagulant or an antiplatelet.

In an interview with Administrator #1 on 11/16/2023 at 2:45 p.m., she stated Resident #30's MDS assessment was to be correct and accurate.

2. Resident #68 was admitted to the facility on 10/4/2023, and diagnoses included hypertension and kidney disease.

The admission Minimum Data Set (MDS) assessment dated 10/10/2023 indicated Resident #68 was cognitively intact and was receiving anticoagulants (a medication that inhibits the clotting of the blood).

A physician order dated 10/4/2023 was written for Resident #68 to receive Aspirin Delayed Release 81 milligrams(mg) daily for anticoagulant therapy.

F 641

utilizing the MDS Accuracy Tool. This audit is to ensure accurate and complete coding of the MDS assessment to include section N for use of antiplatelets. The Director of Nursing, MDS Coordinator and/or Quality Assurance nurse will address all areas of concern identified during the audit to include completion of resident assessment and/or retraining of the MDS nurses when indicated. The Administrator will review the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed.
The Quality Assurance nurse will forward the results of MDS Accuracy Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 641	Continued From page 12 On 10/6/2023, the order was re-written as Aspirin Delayed Release 81mg daily for coronary artery disease. The October 2023 and November 2023 Medication Administration Records recorded Resident #68 had received Aspirin Delayed Release 81mg daily from 10/4/2023 to 10/31/2023 and from 11/1/2023 to 11/15/2023 when reviewed. In an interview with the MDS Nurse #2 on 11/16/2023 at 9:33 a.m., she stated Resident #68 use of Aspirin Delayed Release was coded as an anticoagulant and should have been coded as an antiplatelet. She explained she started in the MDS department in October 2023, and she was learning all the information in the MDS process as well as the new MDS guidelines that were implemented October 2023. She stated she hit the wrong code when coding the use of Aspirin Delayed Release. In an interview with Administrator #1 on 11/16/2023 at 2:45 p.m., she stated Resident #68's MDS assessment was to be correct and accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		12/22/23

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F 656	Continued From page 13 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff	F 656	Resident #125 no longer resides in the	

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interviews, the facility failed to develop a person-centered comprehensive care plan for 1 of 23 residents (Resident #125) reviewed for comprehensive care plans.

Finding included:

Resident #125 was admitted to the facility on 10/6/2023. Resident #125 was discharged on 10/13/2023 to the hospital and was re-admitted to the facility on 10/23/2023. His diagnoses included lower respiratory infection.

Nursing documentation dated 10/6/2023 reported Resident #125 was admitted to the facility with a peripherally inserted central catheter (PICC) and was receiving intravenous antibiotics.

Physician orders dated 10/6/2023 included changing PICC line dressing one time a week and as needed. Physician orders dated 10/23/2023 included changing PICC line dressing to upper right arm every seven days and administering Piperacillin Sodium-Tazobactam Solution (an antibiotic) 3.375grams intravenously every eight hours for lower respiratory infection for 36 days.

The most recent 5-day admission Minimum Data Set (MDS) assessment dated 10/29/2023 indicated Resident #125 was cognitively intact, had intravenous access and was receiving intravenous medications and antibiotics.

A review of Resident #125's care plan dated revised on 11/15/2023 did not include a focus for intravenous therapy.

On 11/15/2023 at 7:58 a.m., Nurse #1 was

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facility. On 11/16/23 MDS nurse updated Resident #125's for use of intravenous antibiotics.
On 12/11/23, the Quality Assurance Nurse, and Director of Nursing initiated an audit of care plans for all resident receiving intravenous therapy to include intravenous antibiotics to ensure the care plan is person centered with measurable objectives and timeframes to meet the resident's needs. The Quality Assurance Nurse, Director of Nursing, and Resource Nurse will address all concerns identified during the audit to include updating care plan when indicated and education of staff. The audit will be completed by 12/22/23.
On 12/11/23, the Director of Nursing and/or Quality Assurance Nurse (QA) initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the residents medical, nursing, and mental/psychosocial needs to include but not limited to intravenous therapy.
In-service will be completed by 12/22/23.
After 12/22/23 any nurse who has not completed the in-service will be in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Care Plans.
The Quality Assurance Nurse and Director of Nursing will review care plans for all residents with new orders for intravenous therapy weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool.

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F 656	Continued From page 15 observed connecting Piperacillin Sodium-Tazobactam Solution 3.375grams intravenously to Resident #125's PICC located in the right upper arm. On 11/16/2023 at 9:40 a.m. in an interview with MDS Nurse #1, she stated the MDS staff was responsible for the initial comprehensive care plan, and Resident #125 had received antibiotics per intravenous therapy since admitted to the facility on 10/6/2023. After reviewing Resident #125's care plan, she said the use of intravenous therapy for antibiotics was not included in Resident #125's comprehensive care plan, and she couldn't explain why intravenous therapy for antibiotics was not a part of the care plan. On 11/16/2023 at 2:45 p.m. in an interview with Administrator #1, she stated MDS #1 or Nurse Manager on the unit was to complete a comprehensive person-centered care plan for Resident #125 that included the use of a PICC for intravenous antibiotic therapy.	F 656	This audit is to ensure resident care plan is person centered for use of intravenous therapy with measurable objectives and timeframes to meet the resident's needs. The Quality Assurance Nurse and Director of Nursing will address all concerns identified during the audit to include updating the care plan when indicated and/or re-education of staff. The Nursing Home Administrator will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance nurse will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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, observations, resident interview and staff interviews, the facility failed to change a dependent resident's incontinent soiled brief due to meal trays being passed on the hall (Resident #30) and to provide mouth care after a resident requested mouth care (Resident #4) for	F 677	On 11/12/23, the nursing assistant provided incontinent care to resident # 30 under the oversight of the Nurse Manager. On 11/16/23, the nursing assistant provided oral care per resident preference	12/22/23

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2 of 8 residents reviewed for activities of daily living.

Findings included:

1. Resident #30 was admitted to the facility on 11/02/2022, and diagnoses included stroke and dementia.

Resident #30's care plan dated 11/8/2022 for urinary incontinence included an intervention to provide perineal care after each incontinent episode. The care plan for activities of daily living reviewed last on 8/28/2023 included interventions for providing total assistance in toileting for incontinence of urine and stool.

The annual Minimum Data Set (MDS) assessment dated 11/7/2023 indicated Resident #30 was moderately cognitively impaired and was dependent on assistance with toileting. The MDS further indicated Resident #30 was always incontinent of urine and stool.

On 11/12/2023 at 10:41 a.m. in an interview with Resident #30, she stated she was "lying in mess" and needed to be changed since this morning before breakfast. Resident #30's call light was observed on. There were no foul odors noted.

On 11/12/2023 at 10:41 a.m. in an interview with Resident #30's assigned Nurse #3 who was standing in the hall at a medication cart, she stated she had told assigned Nurse Aide (NA) #4 Resident #30 needed her adult brief changed.

On 11/12/2023 at 10:43 a.m., the Business Office Manager was observed entering Resident #30's room and informing Resident #30 she would get

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for resident #4.
On 12/11/23, the Quality Assurance Nurse, Treatment Nurse, Unit Manager and Resource Nurse initiated an audit of activities of daily living (ADL) care of all residents to ensure residents were assisted with ADL care to include but not limited to oral care per resident preference and/or assistance with toileting/incontinent care. Audit included providing assistance with toileting/incontinent care during mealtime. The Quality Assurance Nurse, Unit Manager and Resource Nurse will address all concerns identified during the audit to include assisting residents with ADL care and education of staff. Audit will be completed by 12/22/23.
On 12/11/23, the Admission Director, Social Worker and/or Activities Director initiated resident questionnaires with all alert and oriented residents regarding (1) Do you need assistance with ADLs (2) Do staff assist you with toileting or incontinent care when needed to include during mealtimes (3) Do staff provide or assist with oral care/hygiene when needed (4) Do staff assist with bath/showers/shaving/nail care when needed. The Admission Director, Social Worker, Unit Manager, Resource Nurse and/or Activities Director will address all concerns identified during the questionnaire to include updating care plan for resident preferences, assistance with ADL when indicated and education of staff. The questionnaires will be completed by 12/22/23.
On 12/11/23, the Quality Assurance Nurse

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someone to help her because NA #4 was with another resident.

On 11/12/2023 at 10:51 a.m., NA #4 was observed entering Resident #30's room with wash clothes to provide incontinent care.

On 11/12/2023 at 11:32 a.m. in a follow up interview with Nurse #3, she stated she reported to work at 7:00 a.m. and Resident #30's call light had not been on. She explained her assignment consisted of the 300-hall, 400-hall and 500-hall, and she had arrived on the 500-hall when Resident #30's call light came on. She said Resident #30 reported she needed her adult brief changed which she informed NA #4 and forgot to turn off the call light.

On 11/12/2023 at 12:22 p.m. in an interview with NA #4, she stated her assignment consisted of eight residents on the 500-hall. She said she arrived to work at 8:00 a.m. and began helping pass out the breakfast trays. She said Resident #30 told her when passing out the breakfast trays that she needed to be changed, and stated the nursing staff were not allowed to change adult briefs while meal trays were out on the hall. NA #4 explained she had not been able to return to change Resident #30's adult brief due to assisting three residents on the hall with their breakfast meal and bathing another resident who had stool on their hands. NA #4 stated she did not ask for another staff member to provide Resident #30 incontinent care.

On 11/16/2023 at 1:53 p.m. in an interview with the Director of Nursing (DON), he stated nurse aides were to check and provide residents incontinent care every two hours and as needed.

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and/or Director of Nursing initiated an in-service with all nurses and nursing assistants regarding ADL Care with emphasis on providing assistance with ADL care to include but not limited to oral care per resident preference and/or toileting assistance/incontinent care when indicated to include during mealtimes . In-services will be completed by 12/22/23. After 12/22/23, any nurse or nursing assistant who has not received the in-service will be in-service prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in-service during orientation regarding ADL Care.

The Resource Nurse, Unit Manager and Treatment Nurse will complete 10 resident care audits to include audit of resident #4 and resident #30 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit-ADLs. This audit is to ensure all residents were assisted with ADL care to include but not limited to oral care per resident preference and/or toileting assistance/incontinent care when indicated. The Resource Nurses, Unit Manager and Treatment Nurse will address all concerns identified during the audit to include providing assistance with ADLs when indicated and/or re-education of nurse/nursing assistant. The Director of Nursing will review the Resident Care Audit-ADLs weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The Director of Nursing will forward the results of Resident Care Audit-ADLs to the Quality Assurance Performance

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F 677	Continued From page 18 He explained incontinent care could be provided when meal trays were on the hall. However, meal trays could not be in residents' rooms when incontinent care was provided. The DON stated when NA #4 was assisting another resident with feeding, she could not leave that resident to assist Resident #30 with incontinent care. He explained NA #4 should have gone between assisting other residents with feeding to provide Resident #30 her incontinence care. 2. Resident #4 was admitted to the facility on 7/7/2020 with diagnoses including contractures and paraplegia (paralysis of lower body). Resident #4's care plan last reviewed on 8/31/2023 included a focus for activities of daily living/personal care, and interventions included providing constant supervision with physical assistance for personal hygiene and grooming that included cleaning upper dentures daily. The resident guide revised on 10/5/23 included removing dentures nightly and soaking in denture cup with water and denture tablet and brushing and applying the dentures in the morning. The quarterly Minimum Data Set (MDS) assessment dated 10/5/2023 indicated Resident #4 was cognitively intact, required total assistance with bathing and needed assistance setting up or cleaning up with oral hygiene and eating. On 11/12/2023 at 12:09 p.m., Resident was observed with contractures to the left and right hand with 2nd through 5th fingertips turning inward into the palm of the both hands. Resident #4 was unable to extend the left and right fingers to an open palm position voluntarily. She stated	F 677	Improvement Committee (QAPI) monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 677	Continued From page 19 staff did not always assist in cleaning her dentures when she stayed laying in the bed during the day instead of getting up in her chair. On 11/15/2023 at 5:15 p.m., Resident #4 was observed lying in the bed with clean dry lips and a dull red tongue with no coating covering the tongue. Upper and lower dentures were observed in the mouth with small food particles lying in the space between the teeth on the upper denture. On 11/15/2023 at 5:45 p.m. in an interview with Resident #4 while lying in the bed, she said when she received her bath that day, she requested Nurse Aide (NA) #3 to provide her mouth care and denture care. She said NA #3 told her he was too busy and did not provide mouth care and denture care as requested. On 11/16/2023 at 12:10 p.m. in a phone interview with Nurse Aide (NA) #3, he stated Resident #4 requested him to provide mouth care on 11/15/2023 after performing her bath and assisting her to dress. He explained by the time he finished dressing Resident #4 after her bath, he didn't have time to provide mouth care because he was assigned to go to the dining room to assist with lunch trays. NA #3 stated he forgot to return to Resident #4 and provide her oral hygiene because he was busy with the lunch trays in the dining room and on his assigned hall as well as answering call lights. On 11/16/2023 at 1:53 p.m. in an interview with the Director of Nursing, he stated oral hygiene should have been provided as part of Resident #4's activities of daily living daily.	F 677		

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F 758	Continued From page 20	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		12/22/23

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or

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F 758	Continued From page 21 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with staff and Physician #1, the facility failed to clarify an order for psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #55). The findings included: Resident #55 was admitted to the facility on 5/12/23 with diagnoses that included depression. The quarterly Minimum Data Set dated 9/22/23 revealed Resident #55 was cognitively intact with no behaviors. Review of Resident #55's physician orders revealed an order dated 10/19/23 Duloxetine HCL (an antidepressant) 60 milligrams once a day for depression. Review of Resident #55's physician orders revealed an order dated 11/1/23 for Cymbalta (Duloxetine HCL) 30 milligrams once a day for depression. Review of a physician progress note dated	F 758	Resident #55 no longer resides in the facility. On 12/11/23 , Director of Nursing, Quality Assurance nurse (QA), Unit Manager and Resource nurse initiated an audit of all newly ordered psychotropic medications from 11/1/23 to 12/10/23 to include antidepressants. This audit is to ensure that orders are transcribed accurately to the electronic medical record to include but not limited to discontinuing previous orders when medications are adjusted when indicated. The QA nurse, Unit Manager, and Resource will address all concerns identified during the audit to include clarifying orders with the physician when indicated and/or discontinuing orders when medications changes are initiated. The Audit will be completed by 12/22/23. On 12/11/23, the Director of Nursing and/or Quality Assurance Nurse initiated an in-service with all nurses regarding reviewing newly written physician orders to include but not limited to psychotropic medications with emphasis on ensuring	

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F 758	Continued From page 22 11/7/23 read in part, "I did restart Cymbalta at 30 mg daily. May increase to 60 mg at a later date if appropriate. He was chronically on 60 milligrams in the past." Review of Resident #55's November Medication Administration Record (MAR) revealed he received 90 milligrams of Duloxetine HCL November 1 -November 14, 2023. An interview was conducted with Resident #55 on 11/16/23 at 1:120 PM who stated he did not feel any different after the increase in Duloxetine HCL. An interview was conducted with the Medical Director on 11/15/23 at 2:30 PM who stated he made a mistake in prescribing 30 milligrams of Duloxetine HCL on 11/1/23. He reported facility staff should have noticed his error. He reported there was no harm to Resident #55 due to the additional medication. An interview was conducted with the DON on 11/15/23 at 3:00 PM who indicated the dosage of Duloxetine HCL should have been verified.	F 758	(1) orders are transcribed accurately to the electronic medical record to include but not limited to discontinuing previous orders when medications are adjusted if indicated and (2) clarifying duplicate orders or orders not clearly written with the physician. This in-service will be completed by 12/22/23. After 12/22/23, any nurse who has not been educated will receive the in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding review of the re-admission orders to ensure no orders are obtained more than once. The Resource nurse, Unit Manager and Quality Assurance nurse will complete an audit of all newly written physician orders to include antidepressants 5 times a week x 4 weeks then monthly x 1 month during Interdisciplinary Team meeting (IDT) utilizing the orders listing report to ensure orders are transcribed accurately to the electronic medical record to include but not limited to discontinuing previous orders when medications are adjusted if indicated and the nurse clarified duplicate orders or orders not clearly written with the physician. Any areas of concern identified during the monitoring will be immediately addressed by the Resource nurse, Unit Manager and/or Quality Assurance Nurse to include clarifying orders with the physician when indicated and/or staff retraining. The Director of Nursing will review the Orders Listing Report weekly x 4 weeks, then monthly x 1 month to ensure all concerns are addressed.	

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F 758	Continued From page 23	F 758	The Quality Assurance Nurse will present the findings of the Orders Listing Audit to the Quality Assurance and Performance Improvement (QAPI) committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
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 record review, observations and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by the two medication errors that occurred out of the twenty-seven opportunities when Nurse #1 mixed two crushed medications and administered via gastrotomy tube for 1 of 6 residents observed for medication administration (Resident #125). This resulted in a medication error rate of 7.41% for the facility. Findings included: Resident #125 was re-admitted to the facility on 10/23/2023, and diagnoses included lower respiratory infection and gastrostomy. Physician orders dated 10/24/2023 included orders for Finasteride 5 milligrams (mg) via	F 759	Resident #125 no longer resides in the facility. On 11/29/23 hall nurse attempted to educate family on medication administration via gastrostomy tube and spouse declined education stating she had been administering his medications via gastrostomy tube since prior to admission to hospital. On 12/11/23, Nurse # 1 was provided with retraining by the Quality Assurance Nurse (QA) on medication administration to include administering medications via peg tube. On 12/11/23, the Director of Nursing conducted a medication pass audit with Nurse # 1 to ensure all medication was administered according to the physician's orders to include but not limited to administering medications via	12/22/23

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gastrotomy tube and Magnesium Oxide 400mg via gastrotomy tube. Physician orders dated 11/14/2023 included an order to flush the gastrostomy tube with 50 milliliters (mL) water before and after medication administration and to flush with 15 mL of water in between each medication.

On 11/15/2023 at 7:58 a.m., an observation of medication administration via gastrostomy tube was observed for Resident #125. Nurse #1 was observed crushing Magnesium Oxide (an over-the-counter supplement) 400 milligram (mg) tablet and placing the contents into a medication cup. She then was observed crushing Finasteride (a medication used to treat enlargement of the prostate gland) 5 mg tablet and placing the contents into a separate medication cup. After entering Resident #125's room with the two crushed medications in separate medication cups, Nurse #1 was observed adding water to each medication cup to dissolve the crushed contents into water. Nurse #1 was observed connecting a new piston syringe to the gastrostomy tube and did not flush the gastrotomy tube with 50 mL of water as ordered by the physician before administering medications. Nurse #1 was observed combining and mixing the content of the two medications cup into one medication cup and pouring the two mixed medications into the piston syringe for administration via gastrotomy tube. Since Nurse #1 administered the two medications together, she was unable to administer the 15 mL of water between the two medications as ordered by the physician. Nurse #1 was observed flushing the gastrostomy tube with 50 milliliters (mL) of water after the two mixed medications were administered, disconnecting the piston syringe

F 759

gastrostomy tube (GTube) per facility protocol.
On 12/11/23, the Quality Assurance Nurses and Director of Nursing initiated medication pass audit for all nurses to ensure all medications were administered according to the physician’s orders to include administration of medications via gastrostomy tube. Any areas of concern identified during the audits will be immediately addressed by the Quality Assurance Nurse, Unit Manager and/or the Resource nurse to include additional staff training The audit will be completed by 12/22/23. After 12/22/23 any nurse who has not completed the med pass audit will complete upon next scheduled work shift.
On 12/11/23, an in-service was initiated by the Director of Nursing and Quality Assurance Nurse for all nurses regarding (1) Administering Medications via Gastrostomy Tube with emphasis flushing gastrostomy tube prior to administering and administering water between each medication per physician orders and (2) Rights of Medication Administration with emphasis on administering medications to the right resident, right dose, right route and per physician orders. The in-service will be completed by 12/22/23. After 12/22/23 any nurse who has not received the in-service will receive it prior to the next scheduled visit. All newly hired nurses will be in-service during orientation.
The Quality Assurance Nurse and Director of Nursing will complete 5 Medication Pass Audits with nurses to include nurse #1 weekly x 4 weeks, then monthly for 1

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F 759	Continued From page 25 and clamping the gastrostomy tube. On 11/16/2023 at 11:21 a.m. in an interview with Nurse #1, she stated she was nervous and knew she had messed up in the medication administration when she didn't flush the gastrotomy tube with 50 mL water before the medication administration and flushing with 15 mL after giving each medication as ordered. She explained the reason for mixing the two medications was because the Finasteride medication was such a small amount. She stated the two medications should have been given separately. On 11/16/2023 at 1:53 p.m. in an interview with the Director of Nursing, he stated Nurse #1 should have given the medications separately and flush the gastrotomy tube prior to the medication administration and between each medication as ordered.	F 759	month. This audit is to ensure medications were administered using the rights of medication administration and to ensure the nurse flushed gastrostomy tube prior to administering medications and between each medication administered. Any areas of concern identified during the audit will be immediately addressed by the Quality Assurance Nurse and Director of Nursing to include prompt assessment of the involved resident, notification of the physician, if applicable, and/or providing additional staff training. The Nursing Home Administration will review the Medication Pass Audit forms weekly for 4 weeks, then monthly for 1 month, to acknowledge completion of the audit. The Quality Assurance Nurse will present the findings of the Medication Pass Audit forms to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months to review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/22/23

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F 761	Continued From page 26 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to (1) discard expired medications in 1 of 3 medication storage rooms (Nurse Station #2 medication storage room) and (2) discard expired medications in 2 of 4 medication carts (600-hall medication cart and 300-hall medication cart) observed for storage and labeling. Findings included: 1. On 11/15/2023 at 3:55 p.m. in the observation of Nurse Station #2 medication storage room with the Director of Nursing (DON), the following were observed: - Six unopened vials of Ampicillin (an antibiotic for reconstitution) in a clear plastic bag with no label and each vial with a manufacturer's expiration date of 10/2023 were observed on a cart on the shelf underneath the locked emergency medication box. The DON removed	F 761	On 11/17/23, the administrative nurses to include Quality Assurance Nurse, Unit Manager and Resource nurse removed and discarded all expired medications and/or medications that arenot label with an “open” or “use by” date per facility protocol in the medication room on Station 2, the 600-hall medication cart and the 300-hall medication cart. On 12/11/23, the Resource Nurses, Treatment Nurse, and Quality Assurance Nurse (QA) initiated an audit of all medication carts and medication storage rooms. This audit is to ensure medications are labeled with an “open” or “use by” date per facility protocol and that all expired medications are removed. The Resource Nurses, treatment nurse and or QA nurse will address all concerns identified during the audit to include	

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F 761	Continued From page 27 the six vials of Ampicillin from the shelf to return the medication to pharmacy. -Four unopened 100 milliliter (mL) bags of normal saline (NS) with a manufacturer's expiration date 10/2023 located on a cart on the shelf underneath the locked emergency medication box. The DON removed the four bags of NS from the shelf to return the medication to pharmacy. -Two unopened bottles of Calcium 250 milligrams (mg) and Vitamin D3 with a manufacturer's expiration date 6/2023 located in storage cabinet. The DON was given the two bottles of Calcium 250 milligrams (mg) and Vitamin D3 from the cabinet, and the DON stated the bottles would be returned the to pharmacy to discard. - Seven pharmacy mixed and issued intravenous containers of Ampicillin 1 gram labeled delivered on 10/23/2023 and expired on 10/26/2023 located in the medication refrigerator. The DON removed the seven containers of Ampicillin 1 gm from the refrigerator to return to the pharmacy. - Two pharmacy mixed and issued intravenous containers of Daptomycin 500mg labeled delivered on 10/17/2023 and expired 10/27/2023 located in the medication refrigerator. The DON removed the two containers of Daptomycin from the refrigerator to return to the pharmacy. - Ten pharmacy mixed and issued intravenous containers of Merophenem 500 mg labeled delivered on 11/9/2023 and expired 11/14/2023 located in the medication refrigerator. The DON removed the ten containers of Merophenem from the refrigerator to return to the pharmacy.	F 761	removing all expired items, items not labeled with an “open” or “use by” date per facility protocol and/or education of staff. The audit will be completed by 12/22/23. On 12/11/23, the Director of Nursing and/or QA nurse initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on (1) checking medications before administration for expired dates (2) appropriately discarding expired medications per pharmacy policy, and (3) labeling medications with an “open” or “use by” date when indicated. In-service will be completed by 12/22/23. After 12/22/23, any nurse or medication aide who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses and medication aides will be in-service during orientation. The treatment nurse and/or Quality Assurance Nurse (QA) will audit all medication carts and medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. The audit is to ensure medication is labeled with an open date or use by date when opened if indicated and all expired medications discarded per facility protocol. All identified areas of concern will be addressed by the treatment nurse and/or QA nurse during the audit to include dating items when indicated, removal of expired medication and re-training of staff. The Director of Nursing (DON) will review the Medication Audit Tool weekly x 4 weeks then monthly	

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F 761	Continued From page 28 In an interview with the Director of Nursing on 11/15/2023 at 3:55 p.m., he stated he did not know why the six vials of Ampicillin for reconstitution and four bags of normal saline were located on the shelf underneath the emergency medication box. He stated those medications (Ampicillin vials and NS bags) should have been in the locked emergency medication box, and a new locked emergency medication box was exchanged with pharmacy daily. The DON explained the expired intravenous medications observed in the refrigerator were for residents with no IV access, no current order to administer IV medications or had been discharged, and the nurses had not returned the medications to the pharmacy. The DON said the nurse working the night shift (11p-7a) was to check the medication room each night for expirations, and the assigned nurse or the unit nurse manager was to return expired and discontinued resident medications to the pharmacy. On 11/16/2023 at 1:43 p.m. in an interview with the Unit Nurse Manager #1, she stated unit nurse managers were responsible for checking all the medications on the medication carts and in the medication storage rooms for expired medications on Monday, Wednesday, and Friday, and there were no medication storage room and medication cart audit written reports. She explained when checking the medication storage rooms, she had not been checking the medication refrigerator and the cart where the emergency medication box was located for expired medications. She further stated she did not know the procedure in returning medications to the pharmacy.	F 761	x 1 month to ensure all concerns are addressed. The QA nurse will forward the results of Medication Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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Attempts to interview the night shift nurse were unsuccessful.

On 11/16/2023 at 1:53 p.m. in a follow up interview with the Director of Nursing, he stated the medication storage rooms and the medication carts were to be checked by the night shift nurses and the pharmacy monthly.

2. a. On 11/15/2023 at 4:10 p.m., observation of the 600-hall medication cart was conducted with the Director of Nursing (DON). One opened vial of Glarsol Insulin 100 units per milliliter in a medication bottle was observed with an expiration date of 10/5/2023 written on the label of the medication bottle. The label on the vial of Glarsol Insulin recorded the vial was opened on 9/8/2023 and expired in twenty-eight days on 10/6/2023. The DON removed and discarded the expired vial of Glarsol Insulin for Resident #47.

On 11/15/2023 at 4:10 p.m. in an interview with the DON, he stated the vial of Glarsol Insulin should had been removed for the 600-medication cart by the nurses assigned the medication cart and on the night shift (11 p.m. to 7a.m.) by the nurse when checking the 600-hall medication cart for expirations. The DON also stated the pharmacy checked the medication carts monthly for expiration but did not know when the pharmacy came last to the facility to check the medication carts.

On 11/16/2023 at 11:34 a.m. in an interview with Nurse #1, she stated the assigned nurse to the medication cart was responsible for checking the medication for expiration, and expired medications were to be removed and discarded

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F 761	Continued From page 30 from the medication cart. b. On 11/15/2023 at 5:37 p.m., observation of the 300-hall medication cart was conducted with the Director of Nursing (DON), and the following expirations were observed in the top drawer: -Two expired boxes of facility stocked Bisacodyl 10 milligrams (mg) suppositories (one box had 10 bisacodyl suppositories and the other box had 9 bisacodyl suppositories) with a manufacturer's expiration of 6/2023 at the end of each box. The DON removed the two boxes of Bisacodyl suppositories to return to the pharmacy to discard. - Fourteen Promethazine 25 mg suppositories in a clear plastic bag labeled delivered 1/2022 for a resident not residing at the facility with an expiration of 1/24/2023. Each of the fourteen promethazine suppositories were observed stamped with a manufacturer's expiration of 4/2023. The DON removed the fourteen Promethazine suppositories to return to the pharmacy to discard. On 11/15/2023 at 5:37 p.m.in an interview with DON, he stated the unit nurse manager was to check the 300-hall medication cart and return expired medications to the pharmacy. On 11/16/2023 at 1:43 p.m. in an interview with the Unit Nurse Manager #1, she stated unit nurse managers were responsible for checking all the medications on the medication carts and in the medication storage rooms for expired medications on Monday, Wednesday, and Friday, and there were no medication storage room and medication cart audit written reports. She explained the reason for expired medications on	F 761		

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F 761	Continued From page 31 the medication carts was due to multiple nurses rotating in the facility and not placing medications in the right place on the medication cart and were missed during the medication audits. Attempts to interview the pharmacist were unsuccessful. Attempts to interview the night shift nurse were unsuccessful. On 11/16/2023 at 1:53 p.m. in a follow up interview with the Director of Nursing, he stated the medication storage room, and the medication carts were to be checked by the night shift nurses and the pharmacy monthly.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		12/22/23

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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 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

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F 867	Continued From page 33 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 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	F 867		

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F 867	Continued From page 34 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 reviews, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey of 3/5/21, the recertification and complaint survey of 8/25/22, and the revisit and complaint investigation survey of 10/13/22. This was for 4 deficiencies that were cited in the areas of: Formulate Advance Directives (F578), Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plan (F656), and Activities of Daily Living (ADL) Care Provided for Dependent Residents (F677). These deficiencies were recited on the current recertification and complaint survey of 11/16/23. The duplicate citations during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to:	F 867	On 12/11/23, The Facility Consultant initiated an audit of previous citations and action plans from 3/5/21 to 10/13/22 to include F578 Advance Directives, F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan and F677 Activities of Daily Living to ensure the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 12/22/23. On 12/11/23, the Facility Consultant completed an in-service with the Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and	

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Continued From page 35

1. F578 - Based on record review, resident interview and staff interviews, the facility failed to ensure a resident's code status was accurately recorded on the electronic and paper medical record for 1 of 18 residents reviewed for advance directives (Resident #125).

During the recertification and complaint survey of 8/25/22, the facility failed to obtain advance communication for healthcare decision (advanced directive) information on admission for 3 of 3 residents reviewed for advance directives.

An interview with Mobile Administrator #1, Mobile Administrator #2 and the Regional Vice President of Operations on 11/16/23 at 3:11 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through trends based on data collection and plans of correction from previous survey results. Mobile Administrator #1 explained the primary staff member who was responsible for advance directives was the Social Worker who was recently on a leave of absence. She said the former Administrator served as the "back up" for ensuring advance directives were in place and had missed monitoring the advance directives process. Additionally, the Regional Vice President expressed there had been administrative changes at the facility in the past 6-9 months in the Administrator and Director of Nursing roles. She said the company utilized mobile administrators and mobile Directors of Nursing (DON) to bring stability to the facility while they transitioned to a more permanent Administrator and DON.

2. F641- Based on record review and staff interviews, the facility failed to accurately code

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modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process.

All data collected for identified areas of concerns to include F578 Advance Directives, F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan and F677 Activities of Daily Living will be taken to the Quality Assurance committee for review monthly x 3 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if the plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse.

The Facility Nurse Consultant will review the QA meeting minutes monthly x 3 months and quarterly x 1 to ensure the QA committee has maintained and monitored interventions that were put into place for all current citations to include F578 Advance Directives, F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care

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F 867	Continued From page 36 the Minimum Data Set (MDS) assessment for residents receiving Aspirin (an antiplatelet that prevents blood cells clumping together to form a clot) for 2 of 18 residents reviewed for MDS accuracy (Resident #30 and Resident #68). During the recertification survey of 3/5/21, the facility failed to accurately code the MDS assessment in the areas of preadmission screening resident review (PASSR), bathing and anticoagulant medication for 4 of 18 residents whose MDS assessments were reviewed. During the recertification and complaint survey of 8/25/22, the facility failed to accurately code the use of a feeding tube, upper extremity functional limitation in range of motion, cognition, mood, and dialysis on quarterly MDS assessments for 2 of 25 residents reviewed. During the complaint investigation and revisit survey of 10/13/22, the facility failed to accurately code a MDS assessment for pressure ulcer care provided for 1 of 5 resident MDS assessments reviewed. An interview with Mobile Administrator #1, Mobile Administrator #2 and the Regional Vice President of Operations on 11/16/23 at 3:11 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through trends based on data collection and plans of correction from survey results. Mobile Administrator #1 explained the MDS staff who were trained in October 2023 received inaccurate training and thought this contributed to the inaccurate coding. Additionally, the Regional Vice President expressed there had been administrative changes at the facility in the	F 867	Plan and F677 Activities of Daily Living to ensure the QA committee has maintained and monitored interventions that were put into place. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Committee Quarterly x 2 quarters for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

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past 6-9 months in the Administrator and Director of Nursing roles. She said the company utilized mobile administrators and mobile Directors of Nursing (DON) to bring stability to the facility while they transitioned to a more permanent Administrator and DON.

3. F656- Based on record review, observations and staff interviews, the facility failed to develop a person-centered comprehensive care plan for 1 of 23 residents (Resident #125) reviewed for comprehensive care plans.

During the recertification and complaint survey of 8/25/22, the facility failed to develop a comprehensive individualized care plan for 2 of 25 residents reviewed for care plans.

An interview with Mobile Administrator #1, Mobile Administrator #2 and the Regional Vice President of Operations on 11/16/23 at 3:11 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through trends based on data collection and plans of correction from survey results. Mobile Administrator #1 and the Regional Vice President expressed they thought there was a process issue with care plans. They explained the baseline care plan was completed by "front line staff," (charge nurse or nurse manager) and the comprehensive care plan was reviewed by the interdisciplinary team and then followed up by the MDS Nurse. They thought staff turnover in the MDS office, the nurses and nurse managers contributed to the deficient practice. Additionally, the Regional Vice President expressed there had been administrative changes at the facility in the past 6-9 months in the Administrator and Director of Nursing roles. She said the company utilized

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F 867	Continued From page 38 mobile administrators and mobile Directors of Nursing (DON) to bring stability to the facility while they transitioned to a more permanent Administrator and DON. 4. F677- Based on record review, observations, resident interview and staff interviews, the facility failed to change a dependent resident's incontinent soiled brief due to meal trays being passed on the hall (Resident #30) and to provide mouth care after a resident requested mouth care (Resident #4) for 2 of 8 residents reviewed for activities of daily living. During the recertification survey of 3/5/21, the facility failed to provide nail care for 1 of 2 residents who were dependent on facility staff for activities of daily living (ADLs). During the recertification and complaint survey of 8/25/22, the facility failed to provide nail care for 1 of 3 residents reviewed who were dependent on facility staff for ADLs. An interview with Mobile Administrator #1, Mobile Administrator #2 and the Regional Vice President of Operations on 11/16/23 at 3:11 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through trends based on data collection and plans of correction from survey results. Mobile Administrator #1 said she thought Nurse Aide #4 had prioritized another resident with more significant care issues which was why Resident #30 waited longer for care. She added Nurse Aide #3, who didn't provide oral care, simply forgot to return to the resident. She stated these were isolated incidents and did not think there was a trend of deficient practice related to	F 867		

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F 867	Continued From page 39 ADL care. Additionally, the Regional Vice President expressed there had been administrative changes at the facility in the past 6-9 months in the Administrator and Director of Nursing roles. She said the company utilized mobile administrators and mobile Directors of Nursing (DON) to bring stability to the facility while they transitioned to a more permanent Administrator and DON.	F 867		