STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced recertification, follow up, and complaint investigation survey was conducted on 11/27/23 through 12/1/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #F0RK11.	E 000		
F 000	INITIAL COMMENTS A recertification, follow up, and complaint investigation survey was conducted from 11/27/23 through 12/1/23. Event ID# F0RK11 and KIFT12. The following intakes were investigated NC00208557, NC00209073, NC00209075, NC00209149, NC00209773, NC000210093, NC00210408, and NC00210493. 11 of the 11 complaint allegations did not result in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 2 of 2 sampled residents (Resident #179 and Resident #377) who were observed to have a medication at bedside. The findings included: 1. Resident #179 was admitted to the facility on 11/8/23. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD).	F 554	F554 Self Administration of Meds: 1. On 11/28/2023 the unit manager removed oxymetazoline nasal spray from bedside of resident #377 and secured it on medication cart. On 11/29/23 Resident #377 assessed by unit manager with no negative outcomes related to medications at bedside (signs of overdose, or underdose). On 11/29/2023 resident #377 was assessed Unit Manager and is not appropriate for self-medication administration.	12/5/23

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

Electronically Signed | 12/20/2023

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F 554	Continued From page 1 A review of Resident #179's electronic medical record (EMR) revealed a physician order was received on 11/8/23 for the following medications, in part: --108 micrograms (mcg) / activation albuterol HFA (a type of propellant or spray) inhalation aerosol solution (used for the management of asthma or COPD) to be administered as 2 puffs inhaled orally every 6 hours as needed for wheezing; --1 percent (%) diclofenac arthritis pain external gel (a topical formulation of a non-steroidal anti-inflammatory drug) to be applied as 2 grams (g) topically four times a day for pain; --0.65% sodium chloride (saline) nasal spray to be administered as 4 drops in each nostril as needed for congestion. A review of the resident's EMR revealed a medication self-administration assessment dated 11/8/23 was completed. The summary portion of the assessment read, "Resident is not interested in self medication." Further review of Resident #179's EMR revealed there were no physician orders for this resident to self-administer medications. The resident's admission Minimum Data Set (MDS) dated 11/14/23 revealed Resident #179 had intact cognition. An observation and interview were conducted on 11/27/23 at 12:53 PM of Resident #179 as she was sitting on the side of her bed eating her noon meal. The meal tray was placed on her bedside tray table in front of her. At that time, a small medication (med) cup with a white gel was observed to be placed on her bedside tray table within reach of the resident. Upon inquiry,	F 554	On 11/28/2023 the unit manager removed diclofenac gel, saline nasal spray, and albuterol inhaler from bedside of resident # 179 and secured on medication cart. On 11/28/2023 resident #179 assessed by unit manager with no negative outcomes related to medications at bedside (signs of overdose or under dose). On 11/29/2023 resident #179 assessed by Unit Manager and is not appropriate for self-administration of medication. 2. On 11/28/2023 the unit manager audited all resident rooms on 400-hall for medications at bedside. No additional negative findings noted, no additional requests for self-medication administration. On 11/29/2023 the unit manager, assistant director of nursing (ADON), director of nursing (DON), quality assurance (QA) nurse and nurse supervisor audited all resident rooms for medications at bedside. No additional negative findings, no requests for self-administration. On 11/29/2023 DON audited all residents with self-administration with no negative findings. 3. Inservice on medication storage (including self-administration/medications at bedside) with involved nurse completed on 11/28/2023 by unit manager. Licensed nurses and medication aides (including agency) were educated on medication storage (including self-administration/medications at bedside), and self-administration. All	

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F 554	Continued From page 2 Resident #179 reported the gel in the med cup was diclofenac gel. Other items observed to be placed on the bedside tray table included a large tube of 1% diclofenac gel, an albuterol inhaler, and a bottle of saline nasal spray. On 11/27/23 at 4:22 PM, a second observation was conducted of the tube of diclofenac gel, albuterol inhaler, and bottle of saline nasal spray as they sat on the resident's bedside tray table. Resident #179's current care plan (last revised on 11/28/23) was reviewed. The resident was not care planned for the self-administration of medications. An observation was conducted on 11/28/23 at 10:38 AM of the diclofenac gel tube, albuterol inhaler, and saline nasal spray placed on Resident #179's bedside tray table. An interview was also conducted at that time. Upon inquiry, the resident reported she self-administered the medications observed to be at bedside. She stated she used her albuterol inhaler approximately two times daily and applied the diclofenac gel on her knees, hands, and feet two or three times a day to help with her arthritis pain. The resident also reported she typically used the saline nasal spray twice daily. Accompanied by the 400 Hall Unit Manager, an observation was conducted of the resident's medications (albuterol inhaler, diclofenac gel tube, and saline nasal spray) still placed on her bedside tray table on 11/28/23 at 5:00 PM. The Unit Manager was observed as she told the resident she needed to remove the meds from her room and would return them if she could. The Unit Manager commented that nursing staff	F 554	working licensed nurses and mediation aides were in- serviced by unit managers, director of nursing (DON), assistant director of nursing (ADON), shift supervisor, or Quality assurance (QA) nurse on 11/28/2023. Any nurse or medication aide not working will be in serviced prior to completing their first medication pass on the next scheduled day. This in-service will be provided to new licensed nurses and medication aides during orientation, including agency. 4. Beginning 12/6/23 the DON, ADON, QA nurse, and/or unit manager will audit 5 random (to ensure all units are audited) resident rooms 3 times weekly x4 weeks then 3 resident rooms 3 times weekly x 4 weeks to ensure no medications are at bedside or medications are properly secured if self-administration process in place. Results of audit will be presented to quality assurance performance improvement committee monthly by the DON or ADON for review, comment, and revision if needed. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23	

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must have left the medications in the room earlier that day. In response, the resident stated, "They've always been there."

An interview was conducted on 11/29/23 at 3:12 PM with the facility's Director of Nursing (DON). During this interview, the DON reported the facility had a process that needed to be followed to be sure it was safe for a resident to self-administer his/her medications. She stated the medications observed at Resident #179's bedside were removed so the resident could be assessed as part of this process.

An interview was conducted on 11/30/23 at 11:35 AM with the facility's Nurse Practitioner #1 (NP #1). During the interview, the NP was asked what her thoughts were regarding Resident #179 self-administering the medications observed to have been left at bedside. The NP reported she did not want the resident to have these medications at bedside. The NP stated she would not know how often or how much of the meds were administered if the resident was self-administering these medications.

2. Resident #377 was admitted to the facility on 11/9/23. His cumulative diagnoses included hypertensive chronic kidney disease.

A review of the resident's electronic medical record (EMR) revealed a medication self-administration assessment dated 11/9/23 was completed. The summary portion of the assessment read, "Unable to administer medications."

The resident's admission Minimum Data Set (MDS) dated 11/15/23 revealed Resident #377

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had intact cognition.

Resident #377's current care plan (last revised on 11/23/23) was reviewed. The resident was not care planned for the self-administration of medications.

Further review of Resident #377's EMR revealed there were no physician orders for this resident to self-administer medications. A review of Resident #377's physician orders (from the time of his admission to the date of the review on 11/27/23) revealed he did not have a physician's order for oxymetazoline (a decongestant) nasal spray.

An observation and interview were conducted on 11/27/23 at 12:41 PM with Resident #377 as he was lying in his bed with his bedside tray table placed in front of him. A bottle of oxymetazoline nasal spray was observed sitting on his bedside tray table. When the resident was asked about the nasal spray, Resident #377 reported he typically used this medication as one spray in each nostril once a day.

Additional observations were conducted on 11/27/23 at 12:53 PM and 11/28/23 at 10:35 AM of the oxymetazoline nasal spray as it remained placed on Resident #377's bedside tray table.

An interview and observation were conducted with Resident #377 on 11/28/23 at 1:44 PM. At that time, the oxymetazoline nasal spray bottle was observed as having been moved and placed on top of the resident's nightstand. With the resident's permission, the medication was picked up for further inspection. The bottle of nasal spray felt light and did not seem to have any

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liquid left in the bottle. Upon inquiry, Resident #377 reported he used the last of the nasal spray earlier that morning. When asked, the resident reported had purchased the decongestant from a drugstore.

Accompanied by the 400 Hall Unit Manager, an observation was conducted of the resident's oxymetazoline bottle still placed on his nightstand on 11/28/23 at 5:00 PM. The Unit Manager was observed as she obtained the resident's permission to remove the nasal spray bottle from the room.

An interview was conducted on 11/29/23 at 3:12 PM with the facility's Director of Nursing (DON). During this interview, the DON reported the facility had a process that needed to be followed to be sure it was safe for a resident to self-administer his/her medications. She stated the medication observed at Resident #377's bedside was removed so the resident could be assessed as part of this process.

An interview was conducted on 11/30/23 at 11:35 AM with the facility's Nurse Practitioner #1 (NP #1). During the interview, the NP was asked what her thoughts were regarding Resident #377 self-administering the oxymetazoline observed to have been kept at bedside. The NP reported she was not aware the resident used this medication or had it at bedside. She also stated the resident had not complained of having nasal congestion. Regardless, the NP reported she would not have recommended using oxymetazoline for more than 5 to 7 consecutive days and would not have wanted the resident to have the nasal spray at bedside for self-administration.

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F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to allow residents assessed to be safe to smoke the ability to smoke independently at times according to their preferences for 2 of 2 sampled residents (Resident #14 and #26). This practice	F 561	F561 Self Determination (Smoking): 1. On 11/30/2023 Director of Nursing (DON) reviewed the Smoking Assessments for resident #14 and resident # 26 both were assessed to be	12/5/23

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F 561	Continued From page 7 had the potential to affect other safe smokers in the facility. The findings included: An observation was made on 11/28/23 at 1:35 PM of a sign placed on the door leading to the facility's only designated resident smoking area titled, "Smoking Times." The sign read: "The Resident Smoking Porch Will be Open During These Times. Smoking Porch will be closed at 9 PM." Five (5) designated smoking times were listed as to when the Smoking Porch was open. These were: 9:00 am - 10:00 am; 1:00 pm - 2:00 pm; 4:00 pm - 5:00pm; 6:00 pm - 7:00 pm; 8:00 pm - 9:00 pm. An interview was conducted on 11/28/23 at 1:35 PM with Nurse Aide (NA) #1 as she was sitting near the exit to the designated smoking area. During the interview, the NA reported residents were only allowed to smoke at the designated times posted on the door. NA #1 reported she needed to stay in the area in case any smoker (including safe smokers) wanted to go out to smoke so that she could supervise them. a. Resident #14 was admitted to the facility on 6/21/21 with cumulative diagnoses which included diabetes and chronic pain syndrome. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/16/23. The MDS revealed Resident #14 had intact cognition.	F 561	Unsupervised/Independent Smokers. Residents #14 and #26 were educated by the Administrator and Assistant Administrator and DON on the ability to smoke at time of choice on 11/28/2023. 2. On 11/30/2023 residents who choose to smoke were reviewed by QA Nurse and MDS Nurse to ensure safe smoking assessment are completed and current. On 11/30/2023 safe smokers were provided with education by the Administrator and Assistant Administrator on smoking policy (securing of material), and ability to smoke at time of choice. 3. On 11/28/23 education was provided to licensed nurses, certified nursing assistants, activity department, and department heads (including agency) by QA Nurse on smoking policy (including safe smokers may smoke at time of choice). This in-service was added to the orientation for new staff, including agency staff. 4. Beginning 12/6/2023 the director of nursing (DON), assistant director of nursing (ADON), unit manager, administrator, and/or social worker will audit 5 residents 3 times a week x 4 weeks then 3 residents 3 times a week for 4 weeks to ensure if safe smoker resident is allowed to smoke as chooses. The DON is responsible for implementation of the acceptable plan of correction.	

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F 561	Continued From page 8	F 561	Date of Compliance: 12/5/23.	

Resident #14's care plan included an area of focus which indicated he was an "unsupervised smoker" (Date Initiated: 9/28/22; Revision on 11/22/23). The planned interventions included, in part: Instruct resident about the facility policy on smoking: locations, times, safety concerns; The resident can smoke unsupervised.

A review of Resident #14's electronic medical record (EMR) included a Smoking Safety Evaluation dated 11/22/23. The smoking evaluation indicated Resident #14 smoked. The Summary of Evaluation reported the following:
1. Smoking requirement for the resident's safety: Unsupervised smoking.
2. Is a smoking apron required? No.
3. Who stores smoking materials? Facility stores.
4. The following have been provided education on smoking (Facility Policies/Procedures): Resident.
5. The following have been provided with the resident's smoking safety evaluation results: Resident.
6. Plan of Care: Remains Appropriate.

An interview was conducted on 11/29/23 at 11:22 AM with Resident #14. During the interview, the resident confirmed he was only allowed to smoke during the facility's designated smoking times. He stated he would like to smoke more than just during these scheduled times.

b. Resident #26 was admitted to the facility on 7/23/18 with cumulative diagnoses which included diabetes and chronic kidney disease.

Resident #26's current care plan (last revised 8/15/23) included an area of focus which indicated he was an "unsupervised smoker." The

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planned interventions included, in part: Instruct resident about the facility policy on smoking: locations, times, safety concerns; The resident can smoke unsupervised.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/12/23. The MDS revealed Resident #26 had intact cognition.

A review of Resident #26's electronic medical record (EMR) included a Smoking Safety Evaluation dated 11/15/23. The smoking evaluation indicated Resident #26 smoked. The Summary of Evaluation reported the following:
1. Smoking requirement for the resident's safety: Unsupervised smoking.
2. Is a smoking apron required? No.
3. Who stores smoking materials? Facility stores.
4. The following have been provided education on smoking (Facility Policies/Procedures): Resident.
5. The following have been provided with the resident's smoking safety evaluation results: Resident.
6. Plan of Care: Remains Appropriate.

During a Resident Council meeting conducted on 11/29/23 at 3:00 PM, Resident #26 was one of the residents who expressed a wish to smoke at will instead of only being allowed to smoke during designated smoking times. The residents reported they were told when they could go out to smoke but would prefer to go out whenever they wanted to smoke.

A follow-up interview was conducted on 11/30/23 at 9:45 AM with Resident #26. During the interview, the resident stated the facility should

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not be telling folks when they could smoke if they were able to "handle their stuff" (smoke safely).

An interview was conducted on 11/30/23 at 9:49 AM with the facility's Director of Nursing (DON). During the interview, the DON reported that in an attempt to cut back on behavior issues and ensure nursing could "keep an eye on the interactions" between residents, the decision was made to restrict the times all smokers could smoke and to provide supervision during those times. She stated, "We have smoking times, and they (the residents) cannot smoke outside of those times."

An interview was requested by the DON, Assistant Administrator, and Regional Nurse Consultant on 11/30/23 at 10:21 AM. During the interview, the DON reported all smokers were recently reassessed as to whether or not they were safe smokers. The facility's decision to supervise all smokers and designate the smoking times currently posted was discussed with all smokers currently in-house on 11/22/23. The DON reported the change was not intended to take a privilege away from residents, but instead was a measure to keep them safe.

On 11/30/23 at 10:40 AM, an interview was conducted with the facility's District Director of Clinical Services. During the interview, the issues/concerns related to the mandated supervision and restriction of smoking times for residents assessed as safe smokers was discussed. The District Director reported the facility could remedy this practice for the residents who were assessed to be safe smokers.

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F 580	Continued From page 11	F 580		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and	F 580		12/5/23

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	345434	A. BUILDING _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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F 580	Continued From page 12 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to notify the provider in accordance with the physician's order of elevated blood glucose (sugar) levels for 1 of 1 sampled resident (Resident #115) observed to have her blood glucose level checked. The findings included: Resident #115 was admitted to the facility on 11/10/23. Her cumulative diagnoses included diabetes and a history of a kidney transplant. A review of the resident's admission orders included the following medications (meds), in part: --8 units of 100 units/milliliter (mL) NPH insulin (an intermediate-acting insulin) to be injected subcutaneously twice daily for diabetes and scheduled at 7:30 AM and 8:00 PM (Start date of 11/10/23); --7 units of 100 units/mL Humalog insulin (a rapid acting insulin) to be injected subcutaneously three times a day for diabetes. The Humalog insulin was scheduled to be administered at 7:30 AM,	F 580	F580 Notification of Changes: 1. On 11/28/2023 the unit manager assessed resident # 115 with no negative findings (symptoms of hyperglycemia). On 11/28/2023 resident # 115 was seen by the medical provider for elevated glucose with a new order to increase scheduled insulin. 2. On 11/29/2023 blood glucose readings for all current diabetic residents with blood glucose monitoring orders for the past 72 hours was reviewed by director of nursing (DON) to ensure abnormal provider notifications were made as appropriate based on blood glucose results. No additional negative findings. 3. Inservice to licensed nurses (including agency) on following physician orders including for abnormal glucose results (including notification of medical provider). All licensed nurses working in-serviced by unit managers, director of nursing (DON),	

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F 580	Continued From page 13 11:30 AM, and 4:30 PM daily (Start Date 11/10/23); --Additionally, there was an order for 100 units/mL Humalog insulin to be injected in accordance with the resident's sliding scale insulin regimen. This dose of the Humalog insulin was also scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM daily in conjunction with a blood glucose check. The sliding scale insulin was to be administered in addition to the 7 units of Humalog insulin scheduled for mealtime coverage (Start Date 11/10/23): --If the resident's blood glucose was 150 - 200 milligrams (mg)/deciliter (dL), 1 unit of insulin was to be administered. --If the blood glucose was 201 - 250 mg/dL, 2 units of insulin was to be administered. --If the blood glucose was 251 - 300 mg/dL, 3 units of insulin was to be administered. --If the blood glucose was 301 - 350 mg/dL, 4 units of insulin was to be administered, and the provider notified. On 11/28/23 at 2:30 PM, Nurse #2 was observed as she checked Resident #115's blood glucose (sugar) level. The resident's blood glucose result was 424 mg/dL. Nurse #2 returned to the med cart, reviewed the physician's orders to determine the dose of insulin needed, then drew up 11 units of Humalog insulin for administration to the resident. Nurse #2 explained the resident had an order for 7 units of Humalog insulin (scheduled) plus she needed to be given an additional 4 units of Humalog based on her orders for sliding scale insulin (where the dose of insulin administered would be dependent on the resident's current blood glucose level). On 11/28/23 at 2:40 PM, Nurse #2 was observed	F 580	assistant director of nursing (ADON), nursing supervisor, or quality assurance (QA) nurse on 11/29/2023. Any nurses (including agency) not working were in-service prior to completing the first medication pass on the next scheduled day. This education will be provided to new licensed nurses (including agency) during orientation. 4. Beginning 12/6/2023 the DON, ADON, unit manager, QA nurse, and/or nurse supervisor will audit 5 residents three times a week x 4 weeks then 3 residents 3 times a week for 4 weeks to ensure provider notification made for glucose level (if applicable). The results will be presented by DON to the quality assurance performance improvement committee for review, comment, and revision as needed. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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F 580	Continued From page 14	F 580		

as she injected 11 units of Humalog insulin subcutaneously (under the skin) into Resident #115's left arm. Upon return to the med cart, the nurse reported this resident was scheduled to have another check of her blood glucose later that afternoon between 4:00 PM - 4:30 PM.

A second observation and subsequent interview was conducted on 11/28/23 at 4:09 PM as Nurse #2 checked Resident #115's blood glucose level. The resident's blood glucose was 301 mg/dL at that time. When the nurse returned to the med cart to check the resident's insulin orders, inquiry was made as to whether she notified the provider of this resident's 2:30 blood glucose level of 424 mg/dL and/or would notify the provider of her current blood glucose level of 301 mg/dL. Nurse #2 stated, "No, because sometimes she runs higher. She's a brittle diabetic and they're (the providers are) aware." At that time, the nurse was asked to review Resident #115's sliding scale orders for Humalog insulin which provided instructions to notify the provider for a blood sugar of 301 or higher. Nurse #2 reiterated that she did not need to call the provider because she was "told in report" there was no need to call for a high blood sugar due to the resident being a "brittle diabetic."

On 11/28/23 at 4:22 PM, Nurse #2 was observed as she prepared and administered 11 units Humalog insulin injected subcutaneously into Resident #115's right arm.

An interview was conducted with the facility's Director of Nursing (DON) and Nurse #1 on 11/28/23 at 5:43 PM. During the interview, a concern regarding Nurse #2's failure to notify the provider in accordance with Resident #115's

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F 580	Continued From page 15 blood glucose parameters for provider notification was discussed. The DON reported she would expect nursing staff to follow the parameters as to when the provider should be notified. The DON added that education needed to be provided to Nurse #2, as well as the rest of the nursing staff, on following the parameters specified in a physician's order. Nurse #1 stated she would notify the provider of the resident's high blood glucose level results obtained earlier that afternoon. An interview was conducted on 11/30/23 at 11:35 AM with the facility's Nurse Practitioner (NP). During the interview, the NP was asked what her thoughts were with regards to Resident #115's elevated blood glucose results from the afternoon of 11/28/23. The NP responded by stating, "If the order says to notify the provider with parameters given, the nurse needs to notify the provider." The NP reported the blood glucose parameters for provider notification were fairly tight because of the resident's complicated medical history. The NP stated she intended to use the parameters to help gauge the insulin needs for Resident #115 and noted she did increase the resident's NPH insulin doses after she was notified of the elevated blood glucose levels on 11/28/23.	F 580		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		12/5/23

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F 688	Continued From page 16 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed to apply right hand splint for 1 of 3 residents review for range of motion (Resident #28). Findings included: Resident #28 was re-admitted on 4/21/23. Review of his quarterly Minimum Data Set assessment, dated 9/21/23, indicated intact cognition. Resident's diagnoses including right hand contracture and hemiplegia (paralysis of one side of the body). Review of the physician's orders for Resident #28 revealed the order, dated 10/3/22, for occupational therapy (OT) evaluation and treatment as indicated for contracture management. Review of Resident 28's plan of care, dated 10/12/23, revealed his limited physical mobility due to right hand contracture with appropriate goals and interventions, including splinting to right upper extremity in the morning to keep it up to six	F 688	F688 ROM/Splinting: 1. On 11/28/2023 resident 28 was assessed by therapy and determined to still require hand splint, and currently wears hand splint as tolerated. 2. On 12/01/2023 Therapy completed an audit of all residents to ensure splint orders were correct and included documentation. No additional negative findings. 3. On 12/05 the QA Nurse in-serviced licensed nurses, and nursing assistants (including agency) on splint application and documentation. New nursing staff (including agency) will be in-service during orientation. 4. Beginning 12/6/2023 the director of nursing (DON), assistant director of nursing (ADON), quality assurance nurse, unit manager, and/or nursing supervisor will audit 5 residents weekly x 4 weeks, then 3 residents 3 times weekly x 4 weeks	

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F 688	Continued From page 17 hours. Range of motion to right upper extremity prior to placing hand splint. Assess skin for any breakdown before and after splinting. Record review revealed the OT discharge summary for Resident #28, dated 10/22/22, indicated that the resident received resting right hand splint application daily from 10/13/22 to 10/22/22, could tolerate it well for six hours. The resident reached maximum potential and was discharged to the nursing floor. The occupational therapy staff trained the nursing staff to apply/remove splint. Record review of the care tracker for November 2023 revealed that Resident #28 did not receive right hand splint applications. Review of the Medication Administration Records (MAR) for November 2023 for Resident #28 revealed no documentation of the right hand splint application. Record review of the nurses' notes for November 2023 revealed no right hand splint application documented for Resident #28. On 11/28/23 at 10:10 AM, during the observation and interview, Resident #28 was in bed. His right hand was contracted with no splint. The blue color splint was observed on the nightstand in his room. The resident indicated that he required assistance to apply and remove the hand splint. He did not receive splint today and could not recall when he had it on his right hand last time. On 11/29/23 at 9:20 AM, during the observation, Resident #28 did not have a splint on his right hand. The resident indicated that he did not	F 688	to ensure if splint is ordered 1. it is applied per order, and 2. use is documented according to plan of care. Results of the audit will be presented to the quality assurance performance improvement committee monthly by the DON for review, comment, and revision as needed. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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F 688	Continued From page 18	F 688		

receive the hand splint today.

On 11/29/23 at 9:25 AM, during an interview, Nurse Aide #7 was not sure if Resident #28 required the splint application or his right hand contracture. She was assigned for Resident #28 this shift but did not clarify the right hand contracture situation with the nurse.

On 11/29/23 at 9:30 AM, during an interview, Nurse #3 indicated that she was assigned for Resident #28 this shift. Nurse #3 could not recall when the resident had his right-hand splint application last time. She did not check the splint application this morning.

On 11/29/23 at 9:35 AM, during the phone interview, Nurse #15 indicated that she was assigned for Resident #28 first shift on 11/28/23. The resident had diagnoses of hemiplegia with right hand contracture. Nurse #15 was not aware of the splint order and did not observe Resident #28 with right-hand splint.

On 11/29/23 at 9:40 AM, during an interview, the Assistant Director of Nursing (ADON) indicated that Resident #28 had a diagnosis of right hand contracture and physician's order for right hand splint. The ADON was not aware that the resident did not receive the splint.

On 11/29/23 at 9:45 AM, during an interview, the Director of Nursing (DON) expected the staff to follow physician's order. Nurses were responsible for hand splint application on the floor. Nurse aides, who worked under nurses' supervision, could apply the right hand splint for Resident #28 in the morning. DON was not aware that Resident #28 did not receive splinting on 11/28/23 and

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F 688	Continued From page 19 11/29/23. On 11/29/23 at 9:55 AM, during the phone interview, Nurse Aide #8 indicated that on 11/28/23, she worked on the floor, where Resident #28 was resided. She did not observe Resident #28 wearing the hand splint. On 11/29/23 at 11:50 AM, during an interview, the Administrator expected the staff to follow the orders and plan of care for the splint application and document it appropriately in the MAR.	F 688		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		12/5/23

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F 690	Continued From page 20 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to secure the urinary catheter tubing per the physician order on 2 of 4 residents observed for urinary catheters (Resident #64 and #144); failed to keep a urinary catheter bag and/or the catheter tubing from touching the floor to reduce the risk of infection or injury for 1 of 4 residents (Resident #168) reviewed with urinary catheters. Findings included: 1a. Review of the facility's Urinary Catheter Policy, updated on 11/23/23, revealed that the urinary catheter tubing needs to be secured utilizing the leg band. Resident #144 was admitted to the facility on 9/5/22. Resident 144's diagnoses included urinary retention with hydronephrosis (kidney swelling due to urine flow obstruction). Her annual MDS assessment, dated 9/14/23, revealed the resident was cognitively intact. She required extensive assistance with activities of	F 690	F690 Catheters: 1. On 11/29/2023 Resident # 144 was provided with a catheter securing device by treatment nurse. On 11/29/2023 resident's catheter bag was placed on right side of bed using hanging device. On 11/30/2023 Resident #144 was assessed by the provider with no negative findings (infection, pain) related to catheter placement and absence of securing device. On 11/29/2023 resident # 64 was provided with catheter securing device by treatment nurse. On 11/30/2023 resident # 64 was assessed by the provider with no negative findings (infection, pain) related to absence of securing device. On 11/29/23 resident 168's catheter was placed on the right side of the bed using hanging device (off floor). Resident 168 was assessed by provider on 11/28/23 with no negative findings related to catheter bag placement (pain, infection). 2. On 11/29/2023 unit manager, director	

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F 690	Continued From page 21 daily living and had an indwelling urinary catheter and was frequently incontinent of bowel. Review of Resident 144's plan of care, dated 8/28/23, revealed an indwelling urinary catheter related to urinary retention, with interventions including anchoring the catheter to prevent excess tension. Review of the physician's s order for Resident #144, dated 9/19/23, revealed an order for indwelling urinary catheter, catheter care every shift and as needed. On 11/28/23 at 10:50 AM, during the incontinence care observation for Resident #144, provided by Nurse Aide #5, the indwelling urinary catheter tubing was not secured to the resident's leg. There was no anchoring device present on the resident's legs. On 11/28/23 at 10:55 AM, during an interview, Resident #144 indicated she was not sure about securing the urinary catheter tubing and could not recall the anchoring device on her legs. On 11/28/23 at 11:00 AM, during an interview, Nurse Aide #5 confirmed she did not know that Resident #144's urinary catheter tubing was unsecured at the beginning of her shift. She continued it was the responsibility of the nurses to apply the anchors to secure the urinary catheter tubing to the resident's leg. She did not observe the anchoring device on resident's legs. On 11/28/23 at 11:10 AM, during an interview, Nurse #15 indicated she was not aware Resident #144 did not have her urinary catheter tubing secured to the leg, nor did she have the anchor	F 690	of nursing (DON), assistant director of nursing (ADON), quality assurance nurse (QA) nurse, and/or nursing supervisor audited all resident with urinary catheters to ensure collection bag was below bladder and not on floor. No additional negative findings. On 11/29/2023 the treatment nurse audited and placed (when needed) urinary catheter tubing securing device in place for residents with urinary catheter in place. On 11/29/23 residents with urinary catheters in place were reviewed by DON for potential negatives in last 14 days related to securing devices, and/or positioning (infection/pain) with no negative findings. 3. Inservice provided to licensed nurses and nursing aides (including agency) on urinary catheter placement (below bladder, and not on floor) and securing of urinary catheter tubing initiated by DON on 11/29/2023 and completed by DON, ADON, unit manager, and/or nursing supervisor on 12/5/2023. This education will be provided to new licensed nurses, and CNAs (including agency) during orientation. 4. Beginning 12/6/2023 the DON, ADON, unit manager, or nursing supervisor will audit 5 residents 3 times a week x 4 weeks then 3 residents 3 times a week x 4 weeks to ensure urinary catheter bag is correctly placed (not on floor) and securing device in place. This audit will be documented on the (name audit tool). The	

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F 690	Continued From page 22 on her leg. Nurse #15 confirmed that it was the nurses' responsibility to secure the urinary catheter tubing to the resident's leg. Nurse #15 did not check the urinary catheter tubing status at the beginning of her shift today. The nurse aides did not report absences of tubing anchor for Resident #144. 1b. Review of the facility's Urinary Catheter Policy, updated on 11/23/23, revealed that the urinary catheter tubing needs to be secured utilizing the leg band. Resident #64 was admitted to the facility on 9/23/21. His diagnoses included obstructive uropathy (obstruction of the urinary flow) and benign prostatic hyperplasia (enlargement) with lower urinary tract symptoms, which required an indwelling urinary catheter. The recent quarterly Minimum Data Set (MDS) assessment, dated 10/19/23, revealed the resident was cognitively intact, required extensive to total assistance with activities of daily living. Resident #64 had an indwelling urinary catheter and was always incontinent of bowel. Review of Resident 64's plan of care, dated 11/22/23, revealed an indwelling urinary catheter related to obstructive uropathy, with interventions including anchoring the catheter to prevent excess tension. Review of the physician's s order for Resident #64, dated 11/13/23, revealed an order to use an indwelling urinary catheter for obstructive uropathy, provide catheter care every shift and as needed.	F 690	DON will present the results of the audit to the quality assurance performance improvement committee monthly. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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F 690	Continued From page 23	F 690		

On 11/28/23 at 11:20 AM, during the observation of urinary catheter care, provided by Nurse Aide #6 for Resident #64, the indwelling urinary catheter tubing was noted to be unsecured to the resident's leg. There was no anchoring device present on the resident's legs.

On 11/28/23 at 11:30 AM, during an interview, Nurse Aide #6 confirmed she did not know that Resident #64 had his urinary catheter unsecured at the beginning of her shift. She continued it was the responsibility of the nurses to apply the anchors to secure the urinary catheter tubing to the resident's leg. She did not observe the anchoring device on resident's legs.

On 11/28/23 at 11:35 AM, during an interview, Nurse #3 indicated she was not aware that Resident #64 did not have his urinary catheter tubing secured to the leg and he did not have an anchor for the catheter on his leg. Nurse #3 confirmed that it was the nurses' responsibility to secure the urinary catheter tubing to the resident's leg. Nurse #3 did not check the urinary catheter tubing status at the beginning of her shift today. The nurse aides did not report absences of tubing anchor for Resident #64.

On 11/28/23 at 12:50 PM, during an interview, the Director of Nursing (DON) expected the nursing staff to have secured the urinary catheters to prevent injury to the resident and to maintain the urine flow.

2. Resident #168 was admitted to the facility on 11/7/23. His cumulative diagnoses included traumatic spinal cord dysfunction and neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem).

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F 690	Continued From page 24	F 690		

The resident's current care plan included the following areas of focus, in part:
--The resident has a supra-pubic catheter in place (Date Initiated 11/8/23). The planned interventions included: Position catheter bag and tubing below the level of the bladder and away from entrance room door (Date Initiated 11/8/23); Secure catheter to prevent excess tension (Date Initiated 11/8/23).

A review of Resident #168's admission Minimum Data Set (MDS) dated 11/10/23 revealed the resident had intact cognition. He was reported as having an indwelling urinary catheter.

Resident #168's November 2023 Medication Administration Record (MAR) revealed he had just finished a 7-day course of antibiotic treatment administered from 11/16/23 to 11/23/23 for a urinary tract infection.

An observation was conducted on 11/28/23 at 1:45 PM as Resident #168 was lying in his bed asleep. The resident's urinary catheter bag and a portion of the catheter tubing were observed to be lying flat on the floor beside his bed.

A second observation was conducted on 11/28/23 at 3:35 PM as the resident's catheter bag and part of the catheter tubing remained lying flat on the floor beside his bed.

Accompanied by Nurse #2, an observation was made on 11/28/23 at 4:18 PM of the resident's urinary catheter bag lying flat on the floor beside his bed. Nurse #2 was the hall nurse assigned to care for Resident #168. Upon viewing the catheter bag, the nurse was asked to share her

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F 690	Continued From page 25 thoughts about the placement of his catheter bag. The nurse responded by saying, "Oh goodness. That's not where it's supposed to be." The nurse was observed as she attempted to fix the placement of the catheter bag. However, Nurse #1 reported she needed to replace the hook to hang the bag from the Resident #168's bed frame. The nurse was observed as she went to consult with the Unit Manager about the placement of the resident's catheter bag. A follow-up interview was conducted on 11/28/23 at 4:55 PM with Nurse #2. At that time, the nurse reported she replaced the foley catheter for Resident #168 because the hook on the catheter bag was broken. She stated the catheter bag could now be properly secured to the bed frame and kept off the floor. An interview was conducted on 11/28/23 at 5:43 PM with the facility's Director of Nursing (DON). During the interview, the DON reported it was not acceptable to have a urinary catheter bag and/or catheter tubing on the floor. She confirmed the hall nurse had changed Resident #168's foley catheter after the bag was observed lying on the floor. A follow-up interview was also conducted with the DON on 11/29/23 at 3:12 PM. At that time, the DON reported nursing staff education needed to be conducted to reinforce the importance of the proper placement of the catheter bag and tubing for a resident with an indwelling catheter. She stated the catheter bag needed to be placed below the level of the bladder and that it could not rest on the floor.	F 690		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		12/5/23

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F 760	Continued From page 26 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 observations, staff interviews and record reviews, the facility failed to administer mealtime insulin as scheduled by a physician's order. The mealtime insulin was administered more than 3 hours after its scheduled time and within less than two hours of a second dose of mealtime insulin scheduled to cover the next meal. This occurred for 1 of 1 sampled resident (Resident #115) observed to have her blood glucose level checked. The findings included: Resident #115 was admitted to the facility on 11/10/23. Her cumulative diagnoses included diabetes and a history of a kidney transplant. A review of the resident's admission orders included the following medications (meds), in part: --8 units of 100 units/milliliter (mL) NPH insulin (an intermediate-acting insulin) to be injected subcutaneously twice daily for diabetes and scheduled at 7:30 AM and 8:00 PM (Start date of 11/10/23); --7 units of 100 units/mL Humalog insulin to be injected subcutaneously three times a day for diabetes. The Humalog insulin was scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM daily (Start Date 11/10/23). Humalog insulin is a rapid-acting insulin with peak serum blood levels typically seen 30 to 90 minutes after its administration. --In addition, there was an order for 100 units/mL	F 760	F760 Significant Med Errors: 1. On 11/28/2023 unit manager assessed resident # 115 with no negative findings related to late insulin administration (hyperglycemia, hypoglycemia, change in level of consciousness). 2. On 11/28/2023 blood glucose readings for all current diabetic residents with orders for insulin for the past 72 hours reviewed by Director of Nursing to ensure abnormal results were followed up on by a nurse according to order and within time frame. No additional negative findings. 3. In-service on 11/29/2023 by the QA Nurse with licensed nurses and medication aides (including agency) on medication administration including time of administration. This in-service was added to orientation for new licensed nurses and medications aides (including agency). On 12/01/2023 Medication Observations were initiated for all licensed nurses (including agency) by QA Nurse and ADON. All new licensed nurses (including agencies) will have a successful medication observation completed prior to completion of orientation. 4. Starting 12/6/2023 the director of	

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F 760	Continued From page 27 Humalog insulin to be injected in accordance with a sliding scale insulin regimen (where the dose of insulin administered was dependent on the resident's current blood glucose level). This dose of the Humalog insulin was also scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM daily in conjunction with a blood glucose check. The sliding scale insulin was ordered to be administered in addition to the 7 units of Humalog insulin scheduled for mealtime coverage (Start Date 11/10/23) as follows: --If the resident's blood glucose was 150 - 200 milligrams (mg)/deciliter (dL), give 1 unit of insulin; --If the blood glucose was 201 - 250 mg/dL, give 2 units of insulin; --If the blood glucose was 251 - 300 mg/dL, give 3 units of insulin; --If the blood glucose was 301 - 350 mg/dL, give 4 units of insulin and notify the provider. A review of the facility's Meal Delivery Service Times revealed lunch meal trays were scheduled for delivery to Resident #115's hall at 12:00 PM daily. Resident #115's mealtime Humalog insulin coverage for the noon meal was scheduled for administration at 11:30 AM (prior to the meal). On 11/28/23 at 2:30 PM, Nurse #2 was observed as she checked Resident #115's blood glucose level. The resident's blood glucose result was 424 mg/dL. Nurse #2 returned to the med cart, reviewed the physician's orders to determine the dose of insulin needed, then drew up 11 units of Humalog insulin for administration to the resident. Nurse #2 explained the resident had an order for 7 units of Humalog insulin (scheduled) plus she needed to be given an additional 4 units of Humalog based on her orders for sliding scale	F 760	nursing (DON), assistant director of nursing (ADON), unit manager, or nursing supervisor will audit 5 residents 3 x per week x 4 weeks then 3x per week x 4 weeks to ensure medications are given at correct time. Results of this audit will be presented to the quality assurance performance improvement committee for review, comment, and change. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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F 760	Continued From page 28	F 760		

insulin. On 11/28/23 at 2:40 PM, Nurse #2 was observed as she injected 11 units of Humalog insulin subcutaneously (under the skin) into Resident #115's left arm.

A second observation was conducted on 11/28/23 at 4:09 PM as Nurse #2 checked Resident #115's blood glucose level. The resident's blood glucose was 301 mg/dL at that time. On 11/28/23 at 4:22 PM, Nurse #2 was observed as she prepared and administered 11 units Humalog insulin injected subcutaneously into Resident #115's right arm. The administration of this second dose of insulin was only 1 hour and 42 minutes after the first dose of Humalog insulin was observed to be given.

An interview was conducted on 11/28/23 at 4:55 PM with Nurse #2. At that time, the nurse was asked why Resident #115's Humalog insulin was administered more than 3 hours late. Both the scheduled Humalog insulin (7 units) and the sliding scale Humalog insulin (4 units) were scheduled for administration at 11:30 AM but were not administered to the resident until 2:40 PM. Nurse #2 responded by stating the late administration was due to the heavy medication pass workload. The nurse reported it took a long time to get the first med pass done from the morning.

An interview was conducted on 11/28/23 at 5:43 PM with the facility's Director of Nursing (DON) and Nurse #1. During the interview, concerns regarding the late administration of Resident #115's Humalog insulin and short duration of time between the two doses of insulin administered were discussed. The DON stated education would need to be provided to Nurse #2. A

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F 760	Continued From page 29 follow-up interview was also conducted on 11/30/23 at 10:55 AM with the DON. At that time, the DON reported if Resident #115's Humalog insulin was ordered to be given at 11:30 AM, Nurse #2 should have given the insulin within one hour before its scheduled time for administration. An interview was conducted on 11/30/23 at 11:35 AM with the facility's Nurse Practitioner (NP). During the interview, the NP was asked what her thoughts were with regards to the blood glucose results and insulin administrations observed for Resident #115 during the afternoon of 11/28/23. The NP reported she would have wanted to be notified of the blood glucose results (as ordered) so she could have addressed any concerns. The NP stated she intended to use the parameters to help gauge the insulin needs for Resident #115. When asked, the NP reported she would consider the delay in the resident's mealtime insulin coverage (given on 11/28/23 at 2:40 PM) as a significant medication error.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		12/5/23

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F 761	Continued From page 30 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, interviews with staff, and record reviews, the facility failed to: 1) Label medications with the minimum information required, including the name of the resident, on 3 of 4 medication (med) carts (Front 100 Hall Med Cart; 400 Hall Med Cart for Rooms 402 - 420; Middle 100 Hall Med Cart); 2) Accurately label medications to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Front 100 Hall Med Cart; 400 Hall Med Cart for Rooms 404 - 420; Back 100 Hall Med Cart) and 1 of 2 medication store rooms (300 Hall Med Room); and, 3) Discard expired medications on 3 of 4 medication carts observed (Front 100 Hall Med Cart; Middle 100 Hall Med Cart; Back 100 Hall Cart). The findings included: 1. An observation was conducted on 11/30/23 at 8:23 AM of the Front 100 Hall Med Cart in the presence of Nurse #8. The observation revealed the following medications were stored on the med cart:	F 761	F761 Medication Storage: 1. Semaglutide unopened without resident name discarded on 11/30/23 by unit manager. Humalog kwickpen for resident 106 discarded and reordered on 11/30/23 by unit manager. The Lispro kwick pen expired for resident 66 was discarded and reordered by unit manager on 11/30/23. Lantus Solostar without date for resident 106 discarded and reported by unit manager on 11/30/23. Lispro kwick pen without date for resident 157 discarded and reordered by unit manager on 11/30/23. Lispro kwick pen without date for resident 34 discarded and reorded by unit manager on 11/30/23. Novolog flex pen without name or date discarded by unit manager on 11/30/23. Levemir flex pen expired for resident 21 discarded and reordered by unit manager on 11/30/23. Open ketorolac single use vial discarded by unit manager on 11/30/23. Basaglar kwickpen expired for resident 94 discarded and reordered by unit manager	

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F 761	Continued From page 31 a. An opened semaglutide injection pen was stored on the med cart. Semaglutide is an injectable antidiabetic medication used to treat Type 2 diabetes. This injection pen was not labeled with the minimum information required, including the name of the resident it had been dispensed for. The pen was also not dated as to when it had been opened to allow for a determination of its shortened expiration date. b. An opened Humalog Kwikpen dispensed for Resident #106 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the pen was opened on 10/22/23. The Humalog KwikPen had been open for 39 days as of the date of the observation conducted on 11/30/23. According to the product manufacturer, in-use Humalog KwikPens should be stored at room temperature less than 86 degrees Fahrenheit (o F) and used within 28 days. c. An opened Insulin Lispro Kwikpen dispensed for Resident #66 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the pen was opened on 10/25/23. The Insulin Lispro pen had been open for 36 days as of the date of the observation conducted on 11/30/23. According to the product manufacturer, in-use Insulin Lispro KwikPens should be stored at room temperature (less than 86o F) and used within 28 days. d. An opened Lantus Solostar pen dispensed for Resident #106 was stored on the med cart. A	F 761	on 11/30/23. Open tuberculin PPD vial discarded on 11/30/23 by unit manager. 2. On 12/01/2023 the QA Nurse and ADON audited all medication carts and storage rooms for expired, and/or unlabeled medications. Any negative findings were disposed of according to policy and needed replacements obtained from the pharmacy. 3. On 12/01/2023 the QA Nurse in-service licensed nurses and medication aides (including agency) on medication storage (including labeling). This in-service was added to the orientation for new licensed nurses and medication aides. 4. Beginning 12/6/2023 the director of nursing (DON), assistant director of nursing (ADON), unit manager or supervisor will audit medication storage areas 3 times per week x 8 weeks to ensure medications are labeled with resident name, insulin open and dated, no expired medications, and multidose vials have open date and are not expired. This audit will be documented on (name of tool). This audit will be presented to the quality assurance performance improvement committee for review, comment, and update monthly by DON. The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23	

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pharmacy auxiliary sticker adhered to the insulin pen indicated the "Date Opened" was left blank. Resident #106's Lantus Solostar pen was not dated as to when it had been opened to allow for a determination of its shortened expiration date.

According to the product manufacturer, in-use Lantus Solostar pens should be stored at room temperature (less than 86o F) and used within 28 days.

At the time of the observation made on 11/30/23 at 8:23 AM, Nurse #8 was shown the medications identified as having storage concerns. When the nurse was asked how she would know which resident the semaglutide injection pen belonged to, she stated, "You wouldn't." When Nurse #8 was asked how she would know when the Lantus Solostar pen had been opened, she said, "You wouldn't." When the nurse was shown the two insulin pens with opened dates of 10/22/23 and 10/25/23, the nurse stated, "They're no good."

An interview was conducted on 11/30/23 at 11:09 AM with the facility's Director of Nursing (DON). The DON stated all medications dispensed from the pharmacy should be labeled with the minimum required information, including the resident's name. She reported if an identifying sticker fell off the medication, nursing staff needed to let the dispensing pharmacy know or check the facility's back-up stock to replace the medication. During the interview, the DON also discussed the storage and dating of insulin. The DON reported she would expect nursing staff to date opened insulin pens and vials when opened. If a medication was expired or an insulin pen/vial was not dated, the medication needed to be removed from the med cart.

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2. An observation was conducted on 11/30/23 at 9:40 AM of the 400 Hall Med Cart used for rooms 404 - 420. The observation was made in the presence of Nurse #10. It revealed the following medications were stored on the med cart:

a. Two opened insulin pens observed to be stored on the med cart were placed in a plastic bag labeled with Resident #157's name. One of the pens was an Insulin Lispro KwikPen. The Insulin Lispro KwikPen was not labeled with the minimum information required, including the resident's name. The insulin pen was also not dated as to when it had been opened to allow for a determination of its shortened expiration date.

b. An opened Insulin Lispro Kwikpen with the handwritten name of Resident #34 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the "Date Opened" was left blank. Resident #34's Insulin Lispro Kwikpen was not dated as to when it had been opened to allow for a determination of its shortened expiration date.

According to the product manufacturer, in-use Insulin Lispro KwikPens should be stored at room temperature (less than 86o F) and used within 28 days.

An interview was conducted on 11/30/23 at 11:09 AM with the facility's Director of Nursing (DON). The DON stated all medications dispensed from the pharmacy should be labeled with the minimum required information, including the resident's name. She reported if an identifying sticker fell off the medication, nursing staff needed to let the dispensing pharmacy know or

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check the facility's back-up stock to replace the medication. During the interview, the DON also discussed the storage and dating of insulin. The DON reported she would expect nursing staff to date opened insulin pens and vials when opened. If a medication is expired or an insulin pen/vial was not dated, the medication needed to be removed from the med cart.

3. An observation was conducted on 11/30/23 at 8:40 AM of the Middle 100 Hall Med Cart in the presence of Med Aide #2. The observation revealed the following medications were stored on the med cart:

a. An opened Novolog FlexPen was observed to be stored on the med cart. This insulin pen was not labeled with the minimum information required, including the resident's name. A pharmacy auxiliary sticker adhered to the insulin pen indicated the "Date Opened" was 10/12/23. The Novolog FlexPen had been open for 49 days as of the date of the observation conducted on 11/30/23.

According to the product manufacturer, in-use Novolog FlexPens should be stored under refrigeration (between 36 o F and 46 o F) or at room temperature less than 86o F and used within 28 days.

b. An opened Levemir FlexPen dispensed for Resident #21 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the "Date Opened" was 10/1/23. The Levemir FlexPen had been open for 60 days as of the date of the observation conducted on 11/30/23.

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According to the product manufacturer, in-use Levemir FlexPens should be stored at room temperature (less than 86 o F) and used within 42 days.

At the time of the observation made on 11/30/23 at 8:40 AM, Med Aide #2 was shown the medications identified as having storage concerns. The Med Aide reported since she did not administer insulin to the residents, she could not speak to their shortened expiration dates. However, the medication aide was observed as she removed the two insulin pens off the med cart and stated, "I will tell them."

An interview was conducted on 11/30/23 at 11:09 AM with the facility's Director of Nursing (DON). The DON stated all medications dispensed from the pharmacy should be labeled with the minimum required information, including the resident's name. She reported if an identifying sticker fell off the medication, nursing staff needed to let the dispensing pharmacy know or check the facility's back-up stock to replace the medication. During the interview, the DON also discussed the storage and dating of insulin. The DON reported she would expect nursing staff to date opened insulin pens and vials when opened. If a medication is expired or an insulin pen/vial was not dated, the medication needed to be removed from the med cart.

4. An observation was conducted on 11/30/23 at 8:30 AM of the Back 100 Hall Med Cart in the presence of Nurse #9. The observation revealed the following medications were stored on the med cart:

a. An opened, 1 milliliter (ml) vial of 30 milligrams

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(mg) / ml ketorolac for injection (an injectable non-steroidal anti-inflammatory drug) labeled for single use only was stored on the med cart. The pharmacy labeling on the vial of ketorolac indicated it was dispensed from the pharmacy on 1/2/23 for Resident #5. The vial was not dated as to when it had been opened.

b. An opened Basaglar KwikPen dispensed for Resident #94 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the "Date Opened" was 10/3/23. The Basaglar KwikPen had been open for 58 days as of the date of the observation conducted on 11/30/23.

According to the product manufacturer, in-use Basaglar KwikPens should be stored at room temperature (less than 86o F) and used within 28 days.

At the time of the observation made on 11/30/23 at 8:30 AM, Nurse #9 was shown the medications identified as having storage concerns. When asked what she thought about these medications, the nurse stated, "They should have been thrown away."

An interview was conducted on 11/30/23 at 11:09 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observation. During the interview, the DON reported the single-use vial of ketorolac for injection should have been discarded immediately after it was opened and used. The DON also reported she would expect nursing staff to remove expired medications from the med cart.

5. An observation was conducted on 11/30/23 at

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F 761	Continued From page 37 8:45 AM of 300 Hall Med Room in the presence of Nurse #6. The observation revealed one opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vials had been opened. Upon request, Nurse #6 examined the vial and manufacturer box. The nurse confirmed no date was written on the vial or box to indicate when it had been opened. Nurse #6 reported the vial of the Tuberculin PPD injectable medication would need to be discarded due to not knowing when it had been opened. The manufacturer's storage instructions and labeling on the box for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days. An interview was conducted on 11/30/23 at 11:09 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect nursing staff to write the date opened on a vial of Tuberculin PPD and to discard the injectable medication if it was found without being labeled with the date opened.	F 761		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident	F 809		12/5/23

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F 809	Continued From page 38 needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with residents, staff, and the consultant Registered Dietitian (RD) interview, and record review, the facility failed to provide a nourishing snack for all residents and receive an agreement with the resident group for a greater than 14-hour lapse between the evening meal and breakfast meal the following day for residents residing on 6 of 6 resident hallways and 2 of 2 resident dinning rooms. Findings included: A review of the facility's "Meal Delivery Service Times" indicated the meal cart delivery times were scheduled as follows: - The meal cart for the memory care unit was scheduled to be delivered at 4:30 P.M. for dinner and at 7:30 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for the 300 hallway was scheduled to be delivered at 4:55 P.M. for dinner and at 7:55 A.M. for breakfast (indicative of a	F 809	F809 Meals/Snacks: 1. On 11/29/2023 the Administrator and Dietary Manager met, and meals times were updated to ensure the timeframe between evening meal and breakfast did not exceed 14 hours. On 11/29/2023 the Registered Dietician and Dietary Manager ensured appropriate snacks and amount of snacks were provided to nursing for bedtime snack pass. 2. On 12/01/2023 the Administrator audited the last 60 days of grievances with the focus of snacks, and mealtimes. No negatives or trends noted. 3. On 12/01/2023 All licensed nurses, and certified nursing assistants CNAs (including agency) were in-serviced by QA Nurse on offering snacks including	

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F 809	Continued From page 39 15-hour time span between the two meals). - The meal cart for the 100 hallway was scheduled to be delivered at 4:55 P.M. for dinner and at 7:55 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for the 400 hallway was scheduled to be delivered at 5:15 P.M. for dinner and at 8:15 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for the 300 hallway was scheduled to be delivered at 5:15 P.M. for dinner and at 8:15 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for the dining room was scheduled to be delivered at 5:30 P.M. for dinner and at 8:30 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for a second 100 hallway was scheduled to be delivered at 5:45 P.M. for dinner and at 8:45 A.M. for breakfast (indicative of a 15-hour time span between the two meals). - The meal cart for a second 300 hallway was scheduled to be delivered at 5:45 P.M. for dinner and at 8:45 A.M. for breakfast (indicative of a 15-hour time span between the two meals). A Resident Council Meeting was held on 11/29/23 at 3:00 P.M. During the meeting, the residents reported they had not had a meeting with the dietary manager or discussed the number of hours between the dinner and breakfast meals. The Resident Council Members explained the hours for the meals were decided by the facility and further stated the residents did not have any input. The residents' stated snacks were taken to the nursing station on a tray and the resident who saw the snack tray first where the who received a sandwich. The residents stated the other stacks on the tray included fruit cups, pudding, and	F 809	bedtime snacks. No licensed nurse or CNA will be allowed to work after 12/05/2023 until in-service is complete. This in-service was added to the orientation for all new licensed nurses and CNAs (including agency). On 12/02/2023 the Dietary Manager in-serviced all dietary staff on correct mealtimes, and provision of appropriate and adequate snacks, including at bedtime. This in-service was added to the orientation for new dietary staff. 4. Starting 12/6/2023 the Evening Supervisor will audit 5 residents 3 times weekly x 4 weeks then 3 residents 3 times weekly x 4 weeks to ensure 1. bedtime snack offered, and 2. meals arriving per schedule. The Dietary Manager will present findings of the audit to the quality assurance performance improvement committee monthly for review, comment, and revision. The Dietary manager is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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cookies.

An interview was conducted on 11/29/23 at 11:35 A.M. with the Dietary Manager. During the interview, the Dietary Manager was asked about the number of hours between dinner and the following day's breakfast. The Dietary Manager stated he was aware the regulations stated there should be no more than 14 hours between dinner and breakfast. He further explained the residents liked the timing of the meals because many residents did not like to get up early in the morning and having a late delivery time for breakfast allowed them to eat a hot meal. The Dietary Manager was unable to confirm if the Resident Council had agreed to the timing of the meal deliveries or if he had discussed the mealtimes with a resident council group. The Dietary Manager stated sandwiches were made and placed on each hallways snack tray taken out for the residents after the evening meal. The tray was placed at the nursing station for the residents to get a snack.

An interview was conducted on 11/29/23 at 9:44 A.M. with the facility's consultant Registered Dietician (RD). During the interview, the RD reported she was aware there should be no more than 14 hours between the evening meal and the breakfast meal the following day and she had not realized the facility had more than the required time between these two meals. The RD reviewed the delivery service time schedule and confirmed there were 15 hours between the evening meal and breakfast the following day. During the interview, the RD stated she was unsure when the time between meals was increased to 15 hours, and she explained she was unsure if the residents agreed with the extended hours

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F 809	Continued From page 41 between the last evening meal and breakfast the following morning. The RD further stated a nourishment bedtime snack should be available for all residents who wanted a snack. She explained a nourishment snack would be a sandwich with protein and a carton of milk. The RD was unable to provide information on if the residents on each hallway were provided the option to receive a nourishment snack at bedtime. An interview was conducted on 11/30/23 at 12:33 P.M. with the Administration. During the interview, the time lapse of greater than 14 hours between the last evening meal and the following day's breakfast. The Administration stated he was unsure if the Resident Council had discussed the facility changing the hours of the meal deliver times to greater than 14 hours. When asked, the Administrator reported he expected there to be no more than 14 hours between dinner and breakfast.	F 809		
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.	F 812		12/5/23

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F 812	Continued From page 42 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to: 1) ensure dietary staff had all facial hair contained in a face covering and 2) to label, date, and/or remove expired food items stored in 3 of 3 nourishment rooms (200 Hall Nourishment Room/Memory Care, 300 Hall Nourishment Room, and 400 Hall Nourishment Room). The findings included: 1) A kitchen tour was completed with the Dietary Manager on 11/29/23 at 10:05 A.M. During the tour, the Dietary Manager moved around the kitchen and was observed in areas where food was being prepared for the lunch meal. The Dietary Manager wore a hat and beard guard. The beard guard left half his facial hair uncovered. The hair was long enough to stick out above the width of the beard guard. There was a section of hair above the upper lip, a section of hair on each cheek approximately two inches, and no hair was covered where the hair in front of the ear met the hair on the cheek. An interview was conducted on 11/29/23 at 11:35 A.M. with the Dietary Manager. During the interview, the Dietary Manager stated the beard cover he was wearing was designed to only cover his beard. The Dietary Manager stated he was within regulations by wearing a hat and a beard	F 812	812 Food Storage/Sanitation: 1. On 11/29/23 the Unit Manager discarded the following items: 400 hall nourishment room: clear plastic container with potato salad, Styrofoam container with items including chicken, open yogurt container not labeled at room temperature. 300 hall nourishment room: clear plastic up of candy; and 200 hall nourishment room open 20-ounce sports drink, and insulated cup with lid. 2. On 11/29/2023 the Unit Managers audited all nourishment rooms and food storage areas to ensure items labeled, not expired, and in correct storage location (Fridge versus counter). 3. On 12/02/2023 the Dietary Manager in-serviced all dietary staff that it is their responsibility to monitor the nourishment rooms to ensure open food and drinks are dated, items are stored correctly (fridge versus room temperature and out of date food and drinks are discarded. The dietary manager also in-serviced the dietary staff on the monitoring tool used, and frequency of monitoring. This in-service will be part of the orientation process for all newly hired dietary employees.	

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F 812	Continued From page 43 cover. An interview was conducted on 11/29/23 at 11:56 A.M. with the consultant Registered Dietician (RD). During the interview the RD stated any hair that exceeded the length of an average person's arm hair, should be covered when the individual was in the kitchen. The RD explained staff may have to wear two beard guards to achieve the goal of covering the facial hair. The RD further stated if the facial hair was only partially covered by a beard guard, the hair was not contained to prevent contamination with the food and requirements of covering all hair were not met. An interview was conducted on 11/30/23 15 12:33 P.M. with the Administrator. During the interview, the Administrator stated he expected all hair to be covered by a hairnet, hat, or beard guard when staff were working in the kitchen. 2) An observation of the 400 Hall Nourishment Room was conducted on 11/29/23 at 8:55 A.M. The following items were observed with a Transportation Staff Member: - On the counter was a clear round plastic container labeled with a Resident's name and the date of 11/23/23 10:00 P.M. written with a black marker on the lid. The container was half full and contained potato salad. The container was room temperature to touch. - A takeout Styrofoam container with three divided sections that contained lettuce that had turned brown, chicken, cream dressing, and carrots. The container was on the counter, was room temperature, with no labeling. - An 8-ounce yogurt unopened container with a best by date of 11/28/23. The container was on the counter, room temperature, and not labeled	F 812	4. The administrator, Director of Nursing (DON), Dietary Manager (DM), and/or Quality Assurance (QA) nurse will audit 50% of nourishment rooms 3 times weekly x 8 weeks to ensure open food and/or drinks are dated and are not expired, including milkshakes. The administrator will present the results of the audit to the quality assurance perforce improvement (QAPI) committee for review, comment, and revision. The Dietary Manager is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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with a date or name.

An observation of the 300 Hallway Nourishment Room was conducted on 11/29/23 at 10:15 A.M. The following items were observed with the consultant Registered Dietician:
- A clear plastic 8-ounce cup of candy in the refrigerator door and not labeled with a date or name.

An observation of the 200 Hallway Nourishment Room was conducted on 11/30/23 at 11:55 A.M. The following items were observed:
- A 20-ounce bottle of sports drink, 2/3 of the way full and not labeled with a date or name
- An insulated cup with lid and not labeled with a date or name.

An 8-inch x 11-inch paper was laminated and posted on a wall near the refrigerators in each nutrition room titled "Nourishment Refrigerator Policy." The policy read items placed in the refrigerator/freezer will be labeled with the resident's name and date. Items will be discarded after 72 hours of the date placed in the fridge unless it is an item with a manufacturer's expiration date, then it will be discarded upon expiration date. Dietary staff will check nourishment fridge/freezer daily for the need for cleaning, labeling/dating of items.

An interview was conducted on 11/29/23 at 9:01 A.M. in the 400 Hallway Nutrition room with Transportation Staff Member. During the interview, the Transportation Staff Member stated she helped monitor the food in the refrigerator in the nutrition room to ensure the food was discarded when it wasn't labeled with a name and date. The Transportation Staff Member stated all

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food left in the nutrition room should be labeled by staff with the resident's name and the date prior to the food being left. She further explained any food not labeled should be discarded immediately. The Transportation Staff Member stated she had gotten busy the day prior and had not looked in the nutrition room to check to see if food had been labeled and discarded. She further explained she was unsure who had left the food in the nutrition room unlabeled and on the counter.

An interview was conducted on 11/29/23 at 12:08 P.M. with the Dietary Manager. During the interview, the Dietary Manager indicated staff had been educated to label all food brought into the nourishment room with the current date and resident's room number. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated his staff were responsible for checking the nourishment rooms in the morning when they arrived and prior to leaving for the day, to ensure all the food in the refrigerator was labeled with the resident's name and date. The Dietary Manager stated he felt the food placed on the counter was removed from the refrigerator because it wasn't labeled or had expired, and explained the food should have been discarded in the trash and not left on the counter. The Dietary Manager was unable to provide a reason why the food items in the nutrition room refrigerators had not been labeled.

An interview was conducted on 11/29/23 at 9:44 A.M. with the consultant Registered Dietician (RD). During the interview, the RD stated staff have been provided training to label all food placed in the nourishment room with the

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F 812	Continued From page 46 resident's name and the current date. She explained the food should be discarded either by the expiration date or three days after the food had been opened. The RD stated the dietary staff were responsible for checking the nourishment refrigerators each day. An interview was conducted on 11/30/23 at 12:33 P.M. with the Administrator. During the interview, the Administrator stated staff who placed food into the nourishment refrigerator were responsible to place a date and the resident's name on items. The Administrator indicated dietary staff were responsible for cleaning out the nourishment rooms daily and removing items not correctly labeled.	F 812		
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 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		12/5/23

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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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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

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F 867	Continued From page 49 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 dated 9/29/22 and complaint surveys dated 12/14/21, 3/2/23, and 9/28/23 to achieve and sustain compliance. This was for recited deficiencies on a recertification survey on 12/1/23. The deficiencies were in the areas of resident rights, range of motion use of splint, securing resident medication, and use of personal protective equipment (PPE) for infection control. The continued failure during the 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: F561: Based on observations, resident and staff interviews, and record reviews, the facility failed to allow residents assessed to be safe to smoke the ability to smoke independently at times according to their preferences for 2 of 2 sampled	F 867	F867 QAA: 1. On 12/01/2023 the facility Quality assurance performance improvement Committee (QAPI) held a meeting to review the purpose and function of the QAPI committee and review on-going compliance issues. The Administrator, director of nursing (DON), minimum data set (MDS) nurse, quality assurance (QA) nurse, maintenance director, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. 2. On 12/01/2023 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F561, F688, F761, and F880. 3. As of 12/05/2023, the facility QAPI	

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F 867	Continued From page 50 residents (Resident #14 and #26). This practice had the potential to affect other safe smokers in the facility. During the previous complaint survey on 9/28/23, the facility the facility failed to allow a resident to take a shower for 1 of 4 residents. F688: Based on observations, resident, staff interviews and record review, the facility failed to apply a right-hand splint for 1 of 3 residents. During the previous recertification and complaint survey on 9/29/22, the facility failed to apply a palm guard as ordered for 1 of 1 resident. F761: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Label medications with the minimum information required, including the name of the resident, on 3 of 4 medication (med) carts (Front 100 Hall Med Cart; 400 Hall Med Cart for Rooms 402 - 420; Middle 100 Hall Med Cart); 2) Accurately label medications to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Front 100 Hall Med Cart; 400 Hall Med Cart for Rooms 404 - 420; Back 100 Hall Med Cart) and 1 of 2 medication store rooms (300 Hall Med Room); and, 3) Discard expired medications on 3 of 4 medication carts observed (Front 100 Hall Med Cart; Middle 100 Hall Med Cart; Back 100 Hall Cart). During the complaint investigation survey on 3/2/23, the facility failed to secure resident medication for 1 of 2 residents. F880: Based on observations, staff interviews,	F 867	Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports. 4. The Facility QAPI Committee will meet at a minimum monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. The Regional Nurse and Medical Director will attend facility QAPI Committee meetings at a minimum of Quarterly to assist facility with Root Cause Analysis and review the current plans, and will review all QAPI Minutes monthly X 6 months. The Administrator is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23.	

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and record review, the facility staff failed to disinfect a blood glucose meter (glucometer) stored on the med cart and used for an individual resident in a manner that would protect against the cross-contamination from contact with other equipment and surfaces. This was observed for 1 of 1 sample resident (Residents #115) observed to have two consecutive blood glucose (sugar) checks completed.

During the complaint investigation survey of 12/14/21, the facility failed to use eye protection PPE as recommended during the COVID-19 pandemic.

During the recertification and complaint investigation survey of 2/29/22, the facility failed to use a gown PPE as recommended during the COVID-19 pandemic.

During an interview on 11/30/23 at 4:30 PM, the Administrator indicated he was hired two months ago. The Administrator stated the Quality Assurance (QA) Committee members were aware of the prior areas for improvement but the turnover in management had making and sustaining changes difficult. Regarding the repeated citations, the Administrator stated the facility had a new Administrator (himself) and other new management staff. The entire team would start looking at the root cause of the deficiencies and he had plans so that the repeated or reoccurrence of citations would be prevented. Audits and education would be completed as needed. The team would continuously monitor until the deficient areas of concerns have been resolved. Outcomes would be presented to the QA Committee for oversight.

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F 880	Continued From page 52	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		12/5/23

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F 880	Continued From page 53 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility staff failed to disinfect a blood glucose meter (glucometer) stored on the med cart and used for an individual resident in a manner that would protect against the cross-contamination from contact with other equipment and surfaces. This was observed for 1 of 1 sample resident (Residents #115) observed to have two consecutive blood glucose (sugar)	F 880	F880 Infection Control: 1. On 11/28/2023 unit manager disinfected glucometer on 400 hall medication carts as well as storage area for equipment. 2.: On 11/28/2023 director of nursing (DON), assistant director of nursing	

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F 880	Continued From page 54 checks completed. The findings included: A review of the procedure for "Cleaning and Disinfecting the Glucometers" (undated) provided by the facility included the following steps: --Use the provided germicidal / wipes (1:10 ratio bleach); --Wash hands and apply clean gloves; --Wipe the glucometer with the wipe, making sure to wipe all areas of the glucometer; --Keep glucometer wrapped in the wipe for the appropriate dwell time as outlined on the germicidal/wipes product label; --Place the glucometer inside the wipe on a paper towel, on the med cart, to maintain clean surface on med cart; --Remove wipe and place back on paper towel to allow glucometer to air dry completely according to provided wipes product label; --Replace in storage bag/container in medication cart. Information from the manufacturer of the glucometer used for the resident at the facility included a technical brief entitled, "Cleaning and Disinfecting the [Brand Name of Meter]." The section on "Cleaning and Disinfecting FAQ [Frequently Asked Questions]" recommended a blood glucose meter used by an individual resident and not shared be cleaned and disinfected after each use. An observation was conducted of Nurse #2 on 11/28/23 at 2:28 PM as she prepared to do a blood glucose (BG) check for Resident #115. The nurse was observed as she pulled a glucometer (not stored in a case) from the med	F 880	(ADON), unit manager, quality assurance nurse (QA) or nursing supervisor audited all medication carts and glucometers to ensure cleaned according to procedure. 3. In-service on glucometer cleaning by using germicidal wipes (bleach 1:10), wash hands and apply clean gloves, wipe glucometer make sure to wipe all surfaces, keep glucometer wrapped in germicidal wipe for designated dwell time on the product container, place wrapped glucometer on wipe or paper towel on medication cart for designated time, after designated time remove from wipe and place on paper towel, allow to air dry, when dry place in storage container/Area in cart. This in-service was provided to licensed nurses (including agency). All licensed nurses (including agencies) were in-service by unit managers, DON, ADON, nursing supervisor, or QA nurse on 11/28/2023. Any nurses (including agencies) not working will be in serviced prior to completing the first medication pass on the next scheduled day. This in-service will be added to the orientation for new licensed nurses (including agency). 4. Beginning 12/6/23 the DON, ADON, unit manager, or nurse supervisor will observe 5 residents three times weekly x 4 weeks then 3 residents 3 times weekly x 4 weeks to ensure glucometer is cleaned appropriately. The DON will present findings of audit tool to quality assurance performance improvement committee for review, comment, and revision as needed.	

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F 880	Continued From page 55 cart and placed the meter, alcohol wipes, test strip, and a single-use lancet on top of the med cart. Upon inquiry, the nurse reported Resident #115 was the only resident on the hall who currently received BG checks. The nurse donned gloves, picked up the supplies and carried them to Resident #115's room. On 11/28/23 at 2:30 PM, the nurse entered the room and placed the supplies and glucometer directly on the resident's nightstand. Nurse #2 inserted a test strip into the glucometer, then placed it back on the nightstand. Next, the nurse used the lancet to draw a drop of blood from the resident's finger, picked up the glucometer, and touched the strip to the drop of blood. She placed the glucometer back on the nightstand. At 2:33 PM, the nurse picked the glucometer back up and read the BG results. The nurse returned to the med cart and placed the glucometer back on top of the med cart. Prior to leaving the med cart for a medication administration, the nurse replaced the used glucometer back into a drawer of the med cart without putting it inside of a case. The glucometer was not disinfected after it was used to check Resident #115's blood sugar. An interview was conducted with Nurse #2 on 11/28/23 at 2:44 PM. At that time, an inquiry was made as to when Resident #115 would get her next BG check. The nurse reported she was scheduled to have another BG check later that afternoon between 4:00 PM - 4:30 PM. The nurse stated she was going to go on break and was observed to leave the med cart on 11/28/23 at 2:45 PM. On 11/28/23 at 3:59 PM, Nurse #2 was observed as she returned to her medication cart. At 4:05 PM, the nurse pulled the glucometer previously	F 880	The DON is responsible for implementation of the acceptable plan of correction. Date of Compliance: 12/5/23	

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used for Resident #115's BG check from the drawer of the med cart. She gathered the needed supplies (alcohol wipes, single-use lancet, and test strips) and entered Resident #115's room. Upon entering the resident's room, Nurse #2 donned gloves, removed the glucometer from her pocket and placed the meter on the resident's nightstand. On 11/28/23 at 4:07 PM, the nurse picked up the lancet to obtain a blood sample from the resident. At that time, she was requested to stop the procedure and to step out into the hallway. Once in the hallway, the nurse was asked if she would typically disinfect a used glucometer when it left the resident's room (even if it had only been previously used for that same resident). She stated she would not. The nurse was informed that even a resident-dedicated glucometer would need to be disinfected like a shared glucometer if it was taken out of the resident's room due to the potential for cross-contamination. Nurse #2 was then accompanied as she went to the med cart to obtain disinfectant wipes for the glucometer. After looking through the drawers of the med cart, the nurse reported there were no disinfectant wipes on the cart. She stated, "I just had wipes yesterday." Nurse #2 retrieved disinfectant wipes, brought them to Resident #115's room, and was observed as she used the wipes to disinfect the glucometer prior to use.

An interview was conducted on 11/28/23 at 5:43 PM with Nurse #1 and the facility's Director of Nursing (DON). During the interview, concerns regarding the observations made of Resident #115's blood glucose monitoring were shared. A follow-up interview was conducted on 11/29/23 at 3:12 PM with the DON. At that time, the DON reported glucometers needed to be disinfected

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F 880	Continued From page 57 after each use because they were stored on the med cart. In-house education on glucometer disinfection had been initiated with the nursing staff on 11/28/23. She also reported disinfectant wipes needed to be available on each medication cart and an audit was done to ensure their availability.	F 880		