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	345204	A. BUILDING _____ B. WING _____	C 12/22/2023

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STONECREEK HEALTH AND REHABILITATION	455 VICTORIA ROAD ASHEVILLE, NC 28801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 012/18/23 through 12/22/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FSX411	E 000		
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey). An unannounced Recertification and complaint investigation survey was conducted on 12/18/2023 through 12/22/2023. The following intakes were investigated: NC00211245, NC0021104, NC00210947, NC00210921, NC00210469, NC00209891, NC00208413, NC00207828, NC00207540, NC00204913, NC00204590, NC00204572, NC00200285. Event ID # FSX411. 51 of 51 allegations did not result in a deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		1/18/24

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

Electronically Signed | 01/18/2024

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F 583	Continued From page 1 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect private resident health information for 1 of 4 medication carts by leaving confidential medical information unattended and exposed in an area accessible to the public. (Medication cart #1 in East Hall) The findings included: 1.Resident #66 was admitted to the facility on 10/27/23. A continuous observation was made on 12/18/23 from 8:16 AM through 8:18 AM for an unattended medication cart in East Hall. Nurse #2 left the medication cart with the computer screen open when she was in the nurse's station about 50 feet away. The computer screen showed the name,	F 583	1. On 12/18/23, immediate retraining was conducted with Nurse #2 regarding the protection of private health information by keeping the medication cart clear of personal identification and any private health information when left unattended in an area accessible to the public. Topics discussed during education review included, but not limited to: hallway assignment report sheets, meal consumption intake sheets, vital sign flowsheets, and also the screens displaying electronic health information visible on computer/tablet screens. All residents have the potential to be affected by this alleged deficient practice. 100% audits were completed on 12/18/23 by the Director of Nursing	

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F 583	Continued From page 2 picture, and other private health information of Resident #66. The surveyor could access other residents' private health information easily through the computer. Nurse #2 returned to the medication cart 2 minutes later at 8:18 AM. During an interview conducted on 12/18/23 at 8:19 AM, Nurse #2 explained she was in the nurse's station putting away her winter jacket. She had forgotten to minimize the computer screen before leaving the medication cart. She indicated that she had completed the Health Insurance Portability and Accountability Act (HIPAA) training during the orientation and acknowledged that it was her oversight. An interview was conducted with Unit Manager #1 on 12/18/23 at 11:17 AM. She stated Nurse #2 was new to the facility. She expected the nurse to minimize the computer screen before leaving the medication cart to protect residents' confidential personal and medical information. During an interview with the Director of Nursing (DON) on 12/19/23 at 11:30 AM, she confirmed Nurse #2 had completed her HIPAA training during the orientation. All nursing staff were scheduled to complete HIPAA re-certification each year. She expected Nurse #2 to minimize the computer screen before leaving the medication cart. It was her expectation for all the staff in the facility to follow HIPAA guidelines all the time. During a phone interview conducted on 12/20/23 at 10:41 AM, the Administrator stated all residents' confidential personal and health information should be protected. It was her expectation for all the staff to follow the HIPAA	F 583	(DON)/Assistant Director of Nursing (ADON)/designee of all medication carts and all publicly viewable computers/tablets to ensure that all electronic medical records were closed/hidden, and all paper documents were covered or turned over when unattended to ensure compliance with not exposing residents personal and medical information in an area accessible to the public. No identified areas of concern were identified during this audit. No additional residents were identified to have been affected by the alleged deficient practice. 2. On 1/15/24 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) educated all licensed and unlicensed personnel on the policy regarding protecting private health information by closing electronic medical records and concealing paper documents containing resident information when left unattended in an area accessible to the public. Any staff out on leave, vacation, or PRN status will be educated prior to returning to their assignment by the Director of Nursing, Assistant Director of Nursing, or assigned designee. All newly hired personnel will be educated on this policy during orientation by the SDC or designee. 3. 100% of medication carts will be monitored using an audit tool to ensure all documents containing private health information are closed/hidden to protect private health information when left	

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F 583	Continued From page 3 guidelines when working in the facility.	F 583	unattended in an area accessible to the public. To ensure continued compliance, audits will be conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), or their designee for all medication carts 5x a week x 2 weeks, then twice weekly x3 weeks, then weekly x4 weeks. 4. The results of these audits will determine the need for further monitoring. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON/designee, for review and to ensure continued compliance with the plan of correction. Completion date of 1/18/24	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		1/18/24

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F 644	Continued From page 4 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for residents with new mental health diagnoses for 2 of 3 residents (Resident #64, #85) reviewed for PASRR. The findings include: 1. Review of Resident #64's medical record revealed the resident had a PASRR level I completed prior to admission dated 08/19/20 and was admitted to the facility on 06/14/23. The resident was diagnosed with post-traumatic stress disorder (PTSD) on 06/15/23 and anxiety disorder on 06/15/23 as part of her admission. No PASRR level II had been completed per Resident #64 medical records. During a telephone interview on 12/20/23 at 11:15 AM with the previous Social Worker (SW) revealed she had been previously employed as the facility SW for the past 8 years and her last day of employment had been on 11/24/23. She stated during her employment as SW she had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted to see if they would require a level II PASRR to be completed and would be notified by nursing if a new diagnosis had been added for a	F 644	1. Resident #64 and Resident #85's medical record was reviewed and a referral for a Level 2 PASSAR screening was made for both due to new mental health diagnosis. A 100% audit was completed on 1/17/24 by the Social Worker and Administrator to identify any residents with newly evident or potential serious mental disorders, intellectual disabilities, related conditions, or with a significant change in assessment for a Level II PASRR review. Any residents identified with needing a Level II PASRR were reviewed and new FL2s and Screening Tools will be completed and submitted to NCMUST for review by 1/18/24. 2. Admissions Coordinator, Social Worker and the MDS Coordinators were educated 1/11/24 by the Administrator on resident assessments and the requirements for PASRR screenings prior to a resident's admission to a Skilled Nursing Facility. A three-step identification process was implemented on 1/11/24 to ensure all residents admitting will have a correct PASRR. The three step process includes the following: 1. Admissions Coordinator reviewing new admit PASRRs, 2. SW monitoring all residents receiving psych visits/services for new diagnosis and ensuring admit PASRRs have correct	

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F 644	Continued From page 5 resident or there had been a change in condition. The SW stated Resident #64 had been admitted to them from the program of all-inclusive care for the elderly program (PACE) and she had simply overlooked the date of the previous PASRR level I and her admission diagnosis, however based on Resident #64 admission diagnosis of PTSD and anxiety disorder and the date of the preadmission PASRR level I she should have completed the paperwork for a PASRR level II. During an interview on 12/21/23 at 5:13 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #64 admission diagnosis of PTSD and anxiety disorder a PASRR level II should have been completed. 2. Review of Resident #85's medical record revealed the resident had a PASRR level I completed prior to admission dated 07/10/23 and was admitted to the facility on 07/12/23. The resident was diagnosed with mood disorder on 09/05/23 and major depressive disorder on 10/06/23. No PASRR level II had been completed per Resident #85 medical records. During a telephone interview on 12/20/23 at 11:15 AM with the previous Social Worker (SW) revealed she had been previously employed as the facility SW for the past 8 years and her last day of employment had been on 11/24/23. She stated during her employment as SW she had been responsible for completing PASRR upon a resident admission, when a change in condition	F 644	listed diagnosis,3. MDS notifying SW of significant changes on resident assessment. Any significant changes in assessment, residents receiving visits from psych services, or diagnosis of mental disorders, intellectual disabilities, or related conditions will be audited and a new PASRR screening will be conducted. 3. The Social Worker will conduct an audit of any residents receiving psych services and newly admitted residents and the Admission Coordinator will review PASRR screenings prior to a new admission to the facility ensuring PASRR has been done and obtaining number. The audits will be completed as follows: weekly for 4 weeks, then every 2 weeks for 4 weeks, and then monthly for 1 month. 4. The Administrator will bring findings of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate effectiveness of training to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 1/18/24	

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F 644	Continued From page 6 or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted to see if they would require a level II PASRR to be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW stated she was familiar with Resident #85 and had simply overlooked his newly added diagnosis of mood disorder and major depressive disorder and a PASRR level II should have been completed. During an interview on 12/21/23 at 5:13 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #85 newly added diagnosis of mood disorder and major depressive disorder a PASRR level II should have been completed.	F 644		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		1/18/24

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F 756	Continued From page 7 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, Consultant Pharmacist, and the Medical Director (MD), the Consultant Pharmacist the facility failed to ensure an approved gradual dose reduction (GDR) was implemented and provide a recommendation during subsequent medication regimen reviews (MRRs). The Consultant Pharmacist also failed to provide correct dosage information of an antianxiety medication when communicating with the physician for a lowest effective dose evaluation for 1 of 5 residents reviewed for unnecessary	F 756	1. The Consultant Pharmacist failed to ensure an approved gradual dose reduction (GDR) was implemented and provide a recommendation during subsequent medication regimen reviews and failed to provide correct dosage information of an antianxiety medication when communicating with the physician for a lowest effective dose for 1 of 5 residents reviewed for unnecessary medications (Resident #22). The DON notified the physician of the missed GDR	

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F 756	Continued From page 8 medications (Residents #22). The findings included: Resident #22 was admitted to the facility on 03/02/20 with diagnoses including anxiety disorder. Review of the physician's orders dated 02/15/22 revealed Resident #22 had an order to receive 2 tablets of Buspirone 5 milligrams (mg) by mouth twice daily for generalized anxiety disorder. Review of medical records revealed the Consultant Pharmacist had conducted MRRs for Resident #22 in the past 10 months on 03/07/23, 04/03/23. 05/08/23, 06/05/23, 07/07/23, 08/02/23, 09/06/23, 10/06/23, 11/06/23, and 12/05/23. On 03/07/23, the Consultant Pharmacist recommended the physician to reduce Resident #22's Buspirone from 10 mg twice daily to 7.5 mg twice daily to minimize falling risks. The physician approved the recommendation and initialed the Consultant Pharmacist Communication to Physician form on 03/21/23. Review of medication administration record (MARs) revealed Resident #22 had received the same dose of Buspirone since its initiation on 02/15/22. The Consultant Pharmacist had failed to follow up to make specified recommendations to the physician or nursing staff in a timely manner to ensure the approved GDR was implemented. On 11/06/23, the Consultant Pharmacist recommended the physician to assess Resident #22's Buspirone to ensure her anxiety disorder	F 756	recommendation and dosage, the physician ordered the current dosage to stay in place for Resident #22. All current facility residents taking antianxiety medications have the potential to be affected by this deficient practice. Effective 1/17/24, current facility residents on antianxiety medications were reviewed by the Administrator and Director of Nursing (DON) for GDR recommendations and correct dosage to include follow up was done. Results were reviewed with physician, nurse practitioner, and pharmacy consultant. 2. The Director of Nursing (DON) educated the pharmacy consultant on drug regime review and recommendations for residents on antianxiety medications. Education was completed on 1/15/24. Any new Pharmacist will be required to receive education before working. 3. The Director of Nursing (DON) will review the pharmacy consultant report and recommendations monthly to ensure residents medications are reviewed by the consulting pharmacist with appropriate recommendations made for GDR and correct dosage. The DON will monitor 5 residents taking medications to treat anxiety to ensure consulting pharmacist make recommendations as necessary to identify correct dosage and follow up for GDR recommendations to be done. Monitoring will be completed monthly x 4 months.	

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F 756	Continued From page 9 was treated with the lowest effective dose. The dosage of Buspirone provided by the Consultant Pharmacist in the communication to the physician was 5 mg twice daily while Resident #22 was receiving 10 mg twice daily at that time. The physician reviewed and agreed that it was the lowest effective dosage for Resident #22 based on the incorrect dosage information provided by the Consultant Pharmacist. The communication form was initialed by the physician on 11/09/23. The significant change in status Minimum Data Set (MDS) dated 12/03/23 assessed Resident #22 with moderately impaired cognition and indicated that she had received antianxiety daily in the 7-day assessment periods. The care plan last revised on 12/06/23 indicated Resident #22 was receiving psychotropic medication related to diagnosis of anxiety. The goals were to remain free from adverse reactions and injury related to psychotropic medications. Interventions included administering medication as ordered and monitoring its effectiveness and adverse effects. During an interview conducted on 12/20/23 at 3:35 PM, Resident #22 stated she had had received 10 mg of Buspirone twice daily since February last year. An interview was conducted with Nurse #3 on 12/21/23 at 10:08 AM. She confirmed Resident #22 was receiving 2 tablets of Buspirone 5 mg twice daily by mouth for anxiety since 02/15/23. During a phone interview conducted on 12/21/23 at 1:45 PM, Unit Manager (UM)#2 confirmed he worked as an "As Needed" unit manager in the	F 756	4. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for four (4) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/18/24	

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F 756	Continued From page 10	F 756		

facility on 03/21/23. He could not recall what had happened and why the Consultant Pharmacist recommendation that had been approved by the physician on 03/21/23 was not implemented.

A phone interview was conducted with the Consultant Pharmacist on 12/21/23 at 2:00 PM. He confirmed he had recommended the physician on 03/07/23 to reduce Resident #22's Buspirone from 10 mg twice daily to 7.5 mg twice daily and the physician had approved his recommendation. He stated he did not follow up with the recommendation and did not notice that the approved recommendation was not being implemented when he did MRRs in the following months. He acknowledged that when he communicated with the physician to evaluate the dosage of Buspirone to ensure it was the lowest effective dose on 11/06/23, he had provided the physician with the incorrect dosage. He would not comment if the incorrect dosage information he provided to the physician could have potentially affected physician's decision.

During an interview conducted on 12/21/23 at 2:41 PM, the DON stated it was her expectation for the Consultant Pharmacist to follow up with all the recommendations approved by the physician to ensure they were implemented and to provide the correct dosage information when communicating with the physician.

During a phone interview conducted with the MD on 12/22/23 at 10:35 AM, he expected the Consultant Pharmacist to provide correct dosage information when communicating with him and expected the facility to implement all the GDRs that he had approved for the resident in a timely manner.

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F 756	Continued From page 11 An interview was conducted with the Administrator on 12/22/23 at 10:58 AM. She expected the Consultant Pharmacist to follow up with all the approved GDRs and provide recommendations to the nursing staff as indicated in a timely manner. She also expected the Consultant Pharmacist to provide correct dosage information when communicating with the physician.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		1/18/24

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F 758	Continued From page 12 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, Consultant Pharmacist, and the Medical Director (MD), the facility failed to implement a gradual dose reduction (GDR) for an antianxiety medication approved by the physician, resulting the resident to receive a higher dose of an antianxiety medication for over 9 months for 1 of 5 residents reviewed for unnecessary medications (Residents #22). The findings included: Resident #22 was admitted to the facility on 03/02/20 with diagnoses including anxiety disorder.	F 758	1. The facility failed to implement a gradual dose reduction (GDR) for an antianxiety medication approved by the physician, resulting in the resident receiving a higher dose of an antianxiety medication for over 9 months for 1 of 5 residents reviewed for unnecessary medications (Resident #22). The Director of Nursing informed the physician the GDR wasn't done and the physician did not want the GDR done at this time and ordered the medication dosage to stay the same. Current facility residents on as needed psychotropic medications have potential to be affected by this deficient practice. All	

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F 758	Continued From page 13 Review of the physician's orders dated 02/15/22 revealed Resident #22 had an order to receive 2 tablets of Buspirone 5 milligrams (mg) by mouth twice daily for generalized anxiety disorder. Review of medical records revealed the Consultant Pharmacist had conducted medication regimen review (MRR) for Resident #22 in the past 10 months on 03/07/23, 04/03/23. 05/08/23, 06/05/23, 07/07/23, 08/02/23, 09/06/23, 10/06/23, 11/06/23, and 12/05/23. On 03/07/23, the Consultant Pharmacist recommended the physician to reduce Resident #22's Buspirone from 10 mg twice daily to 7.5 mg twice daily to minimize falling risks. The physician approved the recommendation and initialed the Consultant Pharmacist Communication to Physician form on 03/21/23. Review of medication administration record (MARs) revealed Resident #22 had received the same dose of Buspirone since its initiation on 02/15/22. The significant change in status Minimum Data Set (MDS) dated 12/03/23 assessed Resident #22 with moderately impaired cognition and indicated that she had received antianxiety daily in the 7-day assessment periods. The care plan last revised on 12/06/23 indicated Resident #22 was receiving psychotropic medication related to diagnosis of anxiety. The goals were to remain free from adverse reactions and injury related to psychotropic medications. Interventions included administering medication as ordered and monitoring its effectiveness and adverse effects.	F 758	current facility residents on as needed psychotropic medications were audited by the Administrator and Director of Nursing (DON) on 1/17/24 to ensure pharmacy recommendations for GRD had been reviewed by the physician with any new orders implemented. No further residents were identified during audit. 2. On 1/15/24 the DON educated current facility nurses, physician and nurse practitioner (NP) on guidelines for unnecessary as needed psychotropic medications and ensuring all GDR recommendations were reviewed by the physician and to implement any new orders. Any staff that did not receive education will not be allowed to work until education has been completed. Education will be added to the New Hire training. 3. The DON will audit five (5) residents on as needed psychotropic medications monthly x four (4) months to ensure GDR recommendations were followed and reviewed. 4. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for four (4) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	

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F 758	Continued From page 14 During an interview conducted on 12/20/23 at 3:35 PM, Resident #22 stated she had had received 10 mg of Buspirone twice daily since February last year. An interview was conducted with Nurse #3 on 12/21/23 at 10:08 AM. She confirmed Resident #22 was receiving 2 tablets of Buspirone 5 mg twice daily by mouth for anxiety since 02/15/23. During a phone interview conducted on 12/21/23 at 1:45 PM, Unit Manager (UM)#2 confirmed he worked as an "As Needed" unit manager in the facility on 03/21/23. He indicated after the physician had approved recommendations made by the Consultant Pharmacist, the physician would either pass the approved recommendation to him in person, leave it on the top of his desk, or pass it to another UM to implement the changes. He could not recall what had happened and why the Consultant Pharmacist recommendation that had been approved by the physician on 03/21/23 was not being implemented. He added normally after he had implemented the changes by placing the order into the computer system, he would pass the recommendations forms back to the Director of Nursing (DON). He added the DON would review the documents to ensure all the recommendations approved by the physician being implemented. A phone interview was conducted with the Consultant Pharmacist on 12/21/23 at 2:00 PM. He confirmed he had recommended the physician on 03/07/23 to reduce Resident #22's Buspirone from 10 mg twice daily to 7.5 mg twice daily and the physician had approved his recommendation. He stated he did not follow up	F 758	Completion Date: 1/18/24	

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F 758	Continued From page 15 with the recommendation and did not notice that the approved recommendation was not being implemented when he did MRRs in the following months. During an interview conducted on 12/21/23 at 2:41 PM, the DON confirmed she did not check to ensure recommendation approved by the physician for Resident #22 was implemented in March 2023. It was her expectation for the UM to implement all the Consultant Pharmacist's recommendations approved by the physician. During a phone interview conducted with the MD on 12/22/23 at 10:35 AM, he expected the facility to implement all the GDRs that he had approved for the residents in a timely manner. An interview was conducted with the Administrator on 12/22/23 at 10:58 AM. She expected the UM to implement all the GDRs approved by the physician in a timely manner. She also expected the DON to double check all the approved GDRs to ensure they were implemented.	F 758		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide adaptive	F 810	1. The facility failed to provide adaptive cup for Resident #26 on his lunch tray on	1/18/24

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F 810	Continued From page 16 equipment for 1 of 1 resident reviewed for adaptive devices (Resident #26). Findings included: Resident #26 was admitted to the facility on 3/31/23 with diagnosis that included stroke affecting the right dominate side. A review of Resident #26's quarterly Minimum Data Set (MDS) dated 9/25/23 revealed moderate cognitive impairment and required set-up assistance with eating. Resident #26 was care-planned for potential malnutrition and dehydration related to a mechanically altered diet and hemiparesis. A listed approach for the care area was to provide adaptive equipment as ordered. The care plan was last revised on 10/5/23. A review of Resident #26's physician orders dated 10/17/23 and last reviewed on 12/5/23 for Mechanical soft diet with thin liquids and special instructions food to be put in a scoop dish for all meals, an adaptive cup at all meals and build up utensils for the left hand. An observation of the lunch meal tray line on 12/20/23 at 11:53 AM found Resident #26 did not receive adaptive cup on their meal tray that was listed on the meal ticket. The observations revealed there were no adaptive cups at the ready for the meal trays. An observation of Resident #26 and review of his meal ticket was conducted while he was eating lunch in his room on 12/20/23 at 1:01 PM. The observation found his meal tray did not include an	F 810	12/20/23. Resident #26's evening meal was observed by the Director of Nursing on 12/22/23 with the adaptive cup in place on the tray. All residents have the potential to be affected. On 1/10/24, a review of all residents with adaptive built-up utensils were reviewed to ensure equipment was available for use. No other deficient practice was observed. 2. On 1/15/24, the Director of Nursing/Designee educated all nursing staff, department managers and dietary staff on proper tray setup to ensure residents who have orders with adaptive equipment is on the tray at set-up. Any staff that did not receive the education will be required to have the education before working their next shift. New staff will be educated upon hire. On 1/15/23 the Dietary Manager educated all kitchen staff to ensure all ordered adaptive equipment is on the resident tray prior to leaving the kitchen. All new hire kitchen staff will receive education before working their first shift. 3. The Dietary Manager or designee will review 2 meal trays per day, (5) five times per week for 12 weeks to ensure all ordered adaptive equipment is placed on the tray prior to leaving the kitchen. 4. The Dietary Manager will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period. The Administrator	

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F 810	Continued From page 17 adaptive cup. A review of Resident #26's meal ticket read mechanical soft diet with built up utensils, scoop dish, and adaptive cup. Resident #26 stated he sometimes received an adaptive cup with handles and it was easier for him to drink from. The Dietary Manager stated on 12/20/23 at 12:11 PM the staff who pass the trays to the residents will come to the kitchen and ask for the needed adaptive cups, and he said Resident #26's adaptive cup was not placed on the meal tray. On 12/20/23 at 1:09 PM an interview with Nursing Assistant (NA) #1, NA #2, and Nurse #1 was conducted. NA #1 and NA #2 stated the meal card tickets indicated the adaptive cup the residents needed for meals. NA #1 and NA#2 said each resident should receive all items listed on their meal ticket and if something was missing from the meal ticket, they would go to the kitchen to get it. NA #1 stated Resident #26 had improved with drinking out of a juice cup without handles, but it depended on the day if he will use an adaptive cup. Nurse #1 stated when the NAs and Nurses notice an improvement in a resident's feeding or drinking ability or refusal of an adaptive cup a therapy referral was made and therapy will determine if the adaptive equipment was needed. The Rehab Director stated on 12/22/23 at 8:47 AM that an adaptive cup was used by residents to prevent spillage and to increase intake. The Rehab Director said if an NA or Nurse identified a resident who doesn't need an adaptive cup, it was communicated to rehab department. Either occupational therapy (OT) or speech therapy (ST) would watch a resident for 4-5 meals to confirm the adaptive cup was not needed. The Rehab	F 810	is responsible for compliance. Compliance date is 1/18/24	

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F 810	Continued From page 18 Director stated Resident #26 had general difficulty getting food and drink to his mouth due to limited range of motion and poor motor planning. The Rehab Director stated the adaptive cup helped Resident #26 to get drink to his mouth without spilling it. The Rehab Manager stated she was unaware Resident #26 was not receiving or was refusing his adaptive cup. The Registered Dietitian (RD) stated on 12/20/23 at 3:48 PM the adaptive cups should have been provided for the resident. The RD said all items on the meal ticket should be provided to the residents. The Administrator was interviewed on 12/22/23 at 12:32 PM and stated when an order was placed into the electronic health record (EHR) it should be reflected on the meal ticket. The Administrator said the adaptive cup placed on the meal ticket should have been provided to the resident for use.	F 810		
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		1/18/24

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F 812	Continued From page 19 (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 interviews, the facility failed to remove expired food from 1 of 3 kitchen refrigerators and clean and maintain 1 of 1 ice machine air filter vents (2). This practice had the potential to affect food and beverages served to residents. The findings included: An observation of the reach-in refrigerator in the kitchen on 12/18/23 at 8:34 AM found a 3.5-quart container labeled cheesecake dated 12/9/23. The container was located on the top shelf of the reach-in refrigerator and was half-full. An observation of the ice machine in the kitchen on 12/20/23 at 11:39 AM with the Dietary Manager revealed dirty air filter vents (2). Both air filter vents located directly above the door to the ice machine contained a build-up of brown and fluffy debris covering both air filter vents. The Dietary Manager (DM) was interviewed on 12/20/23 at 3:33 PM. The DM stated the cheesecake was left in the refrigerator and was overlooked by the dietary staff and should have been removed. The DM stated the ice machine air filter vents needed to be clean but was unsure whose responsibility it was to clean it (Dietary or Maintenance).	F 812	1. The facility failed to remove expired food from the kitchen refrigerator and clean and maintain the kitchen ice machine air filter vents. The Dietary Manager immediately discarded the expired food item and had the ice machine vents cleaned. Current facility residents have the potential to be affected by this deficient practice. The Dietary Manager completed a 100% audit of food storage including refrigerators, freezers, and dry storage rooms to ensure all food was within usage dates, properly stored, labeled, and items properly disposed of as identified. The Dietary Manager also completed an audit of all kitchen equipment to ensure it was clean and in working order. 2. The Director of Regulatory Compliance completed education with all current dietary staff and the Dietary Manager on proper food procurement, storage, preparation, labeling, and ensuring all kitchen equipment is clean and in working order. Education was completed on 1/17/24, any staff that did not receive the education will not be allowed to work until education has been completed. New facility dietary staff will complete education prior to working their first shift.	

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F 812	Continued From page 20 The Administrator stated on 12/22/23 at 12:32 PM the cheesecake should have been removed after 3 days. The ice machine air vents should have been cleaned and maintained by maintenance. The Administrator said the former Maintenance Manager had the ice machine air filter and vents on a routine cleaning schedule and had not been picked up by the new Maintenance Manager.	F 812	3. The Dietary Manager or designee will audit refrigerators, freezers, dry storage, and nourishment rooms to ensure all food was within usage dates, properly stored, and labeled and kitchen equipment is clean and in working order three (3) times a week for four (4) weeks and weekly for eight (8) weeks. 4. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/18/24	
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	F 867		1/18/24

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F 867	Continued From page 21	F 867		

from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after 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:

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F 867	Continued From page 22 (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects 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	F 867		

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F 867	Continued From page 23 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This was for one repeat deficiency in the area of Food Procurement, Store/Prepare/Serve-Sanitary (F812) originally cited on 6/29/22 during a recertification and complaint investigation survey and subsequently cited on 12/22/23 during the recertification and complaint investigation survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. This tag is cross referenced to:	F 867	1. On 1/11/24, the Medical Director was notified by the Administrator of the repeat dietary citation and the F 867 citation as well as the plans to correct the cited issues. 2. On 1/11/24, the Interdisciplinary Team (IDT) conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citations including F tag F812 and the necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. 3. On 1/11/24, the Regional Director of Operations provided education to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345204	A. BUILDING _____ B. WING _____	C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 24 F812: Based on observations and interviews, the facility failed to remove expired food from 1 of 3 kitchen refrigerators and clean and maintain 1 of 1 ice machine air filter vents (2). This practice had the potential to affect food and beverages served to residents. During the recertification and complaint investigation survey of 6/29/22 the facility was cited for failing to keep stored food off the floor in the dry storage room and in the walk-in freezer. In an interview with the Administrator on 12/22/23 at 12:52 PMQAA meets every month and discussed any areas of previously identified concerns or new concerns for the facility, that included citations from surveys. The areas of concern were tracked from month to month to show improvement or decline. The QAA consisted of the Medical Director, and the interdisciplinary team (IDT) worked together to put interventions into place to correct concerns. The Administrator stated staff turnover in the kitchen that included a new Dietary Manager (DM), and that the expired food items were overlooked which caused repeat concern.	F 867	Interdisciplinary Team (IDT) on maintaining an effective QAPI program to prevent repeat citations. Effective 1/18/24, the Facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not maintained. 4. The Regional Director of Operations will attend QAPI meetings weekly for 4 weeks then, monthly for 2 months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAPI activities. Completion date: 1/18/24	