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	345513	A. BUILDING _____ B. WING _____	C 02/08/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 2/08/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #528W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/05/24 through 2/08/24. Event ID# 528W11. The following intakes were investigated NC00205801 and NC00210109. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of Pre-Admission Screening and Resident Review (PASRR) for 2 of 19 sampled residents whose MDS were reviewed (Resident #56 and Resident #23). The findings included: 1. Resident #56 was admitted to the facility on 6/17/21 with diagnoses which included bipolar disorder and anxiety. Review of the Pre-Admission Screening and Resident Review (PASRR) Level II Determination	F 641	ACCURACY OF ASSESSMENTS: F641 ACCURACY/COORDINATION/CERTIFIED On 2/08/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 5/22/23 Annual Assessment for Resident #56 to reflect accurate coding for Level II PASRR. On 2/8/2024, the MDS Coordinator completed a modification assessment dated 6/10/2023 for Resident #23 to reflect accurate coding of Level II PASRR status.	3/7/24

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

Electronically Signed | 02/23/2024

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

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F 641	Continued From page 1 Notification dated 3/14/23 revealed Resident #56 was appropriate for nursing home placement. The Minimum Data Set (MDS) annual assessment dated 5/22/23 revealed Resident #56 was not coded to reflect his PASRR Level II status. An interview was conducted with the MDS Nurse on 2/07/24 at 10:40 am who confirmed Resident #56 had a PASRR Level II. The MDS Nurse stated she was not sure how she missed the PASRR Level II information for Resident #56 when she completed his annual assessment. An interview was conducted on 2/07/24 at 2:38 pm with the Administrator who revealed the MDS Nurse was responsible to ensure Resident #56's MDS assessments were coded correctly. 2. Review of the Pre-Admission Screening and Resident Review (PASRR) Level II Determination Notification dated 9/13/21 revealed Resident #23 was appropriate for nursing home placement. Resident #23 was admitted to the facility on 6/02/22 with diagnoses which included major depressive disorder and personality/behavioral disorder. The Minimum Data Set (MDS) annual assessment dated 6/22/23 revealed Resident #23 was not coded to reflect his PASRR Level II status. During an interview on 2/07/24 at 2:06 pm the MDS Nurse revealed Resident #23's electronic medical record was not updated with the PASRR Level II information at the time the MDS	F 641	On 02/09/23, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of the most recent comprehensive MDS assessment section “A” from 1/29/24 to 2/12/24 for all residents to include resident #56 and resident #23 to ensure all MDS’s assessments completed are coded accurately for Level II PASRR. The DON will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 3/07/24. On 02/09/24, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for Level II PASRR. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. 10% audit of completed MDS assessments, to include assessments for resident #56 & Resident #23 utilizing the MDS Accuracy Audit Tool will be reviewed by the MDS consultant and/or Director of Nursing weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include Level II PASRR. All identified areas of concern will be addressed immediately by the MDS consultant and/or DON to include	

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F 641	Continued From page 2 assessment was completed. The MDS Nurse stated whoever received the PASRR Level II Determination Notification was responsible to update the electronic medical record with the information. An interview was conducted on 2/07/24 at 2:13 pm with the Admission Director who revealed she was responsible to ensure Resident #23's PASRR Level II status was updated in the electronic medical record when he was admitted to the facility. She stated she must have seen the PASRR Level I information on the medical record from a previous admission and just assumed it was the correct information. The Admission Director stated she completed an audit at a later date and realized she did not have the correct PASRR information listed for Resident #23, so she updated the medical record with the PASRR Level II information. An interview with the Administrator was conducted on 2/07/24 at 2:38 pm. The Administrator stated the PASRR Level II information for Resident #23 should have been updated by the Admission Director, so the information was available so the MDS Nurse could accurately complete the assessment.	F 641	retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The Quality Assurance Nurse (QA) nurse will forward the results of MDS Accuracy Audit Tool to the QA Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		3/7/24

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F 656	Continued From page 3	F 656		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 4 Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to develop a person-centered care plan for 1 of 1residents reviewed for activities (Resident #5). The findings included: Resident #5 was admitted to the facility on 10/05/23 with diagnoses which included stroke and major depressive disorder. The Minimum Data Set (MDS) admission assessment dated 10/11/23 revealed Resident #5 had moderately impaired cognition. Resident #5 reported the following activity preferences were very important: books, magazines, and newspapers to read, listen to music, participate in group activities, participate in religious services, and to be outdoors for fresh air when weather was good. Resident #5's care plan initiated on 10/16/23 and last updated on 2/05/24 revealed she had a care plan in place for daily preferences and activity preferences related to daily care. A care plan goal was in place for Resident #5's daily and activity preferences to be provided through the next review. The care plan had no interventions noted at the time of initial review on 2/05/24. An observation on 2/05/24 at 10:05 am revealed Resident #5 was alone in her room, sitting in her wheelchair with a single coloring sheet and colored pencils. A telephone interview was conducted on 2/05/24 at 11:47 am with Resident #5's Responsible Party (RP) who revealed she had discussed with the	F 656	F656 Develop/Implement Comprehensive Care Plan On 2/08/24, the Administrator updated the care plan for Resident #5 to accurately reflect activities. On 2/07/24, the Minimum Data Set Nurse (MDS) initiated an audit of all resident's care plans. This audit is to ensure residents are care planned for Activities per resident preference. The Director of Nursing (DON) and/or the Unit Manager will address all areas of concern identified during the audit to include updating care plans when indicated. This audit will be completed by 3/07/24. On 2/9/2024, the MDS Consultant, Administrator and the Unit Manager initiated an in-service with the social worker, therapy manager, dietary manager, activities director, and all nurses regarding Comprehensive Care Plans with emphasis on ensuring care plan is resident centered and goal oriented and to ensure that the care plans reflect the resident's most current information all aspects of care to include but not limited to activities. In-service will be completed by 3/07/24. After 3/07/24, any Social Worker, Therapy Manager, Dietary Manager, Activities Director, or Nurses who has not worked or completed the in-service will be educated prior to the next scheduled work shift. All newly hired Social Workers, Therapy Manager, Dietary Manager, Activities Director, and Nurses will be in-service during orientation	

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F 656	Continued From page 5 facility during an interview the activities that Resident #5 enjoyed which included music, coloring, attending church services, and group activities. Resident #5's RP stated when she visited Resident #5, she was most often alone in her room with coloring sheets. An interview was conducted on 2/06/24 at 1:11 pm with the Activity Assistant who revealed the MDS Nurse was responsible to create Resident #5's care plan because she was not able to create care plans. The Activity Assistant stated Resident #5 did participate in group activities for church services and movies at times, but often she delivered coloring pages to her room because she knows Resident #5 enjoyed coloring. An interview was conducted on 2/07/24 at 12:09 pm with Nurse Aide (NA) #1 who revealed he provided care to Resident #5 during the 7:00 am-3:00 pm shift. NA #1 stated he was unsure of what activities Resident #5 enjoyed participating in, but he stated if he knew he would take her to the scheduled activity of her choice. An interview was conducted on 2/07/24 at 1:35 pm with Nurse #2 who he did not know if there was an activity that he could offer for Resident #5 when she was in her room alone. During an interview on 2/07/24 at 1:54 pm with the MDS Nurse she revealed she was responsible for completing the care plan for Resident #5, but she was unable to state why there were no interventions for the activity care plan. The MDS Nurse stated she noticed there were no interventions listed for Resident #5's activity care plan, so she added color with color	F 656	regarding Comprehensive Care Plans. The MDS nurse and the Unit Manager will review all admissions/readmissions 5 times a week x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plan is resident centered and goal oriented and to ensure that the care plans reflect the resident's most current information all aspects of care to include but not limited to activities per resident preference. The DON will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The DON will forward the results of the Care Plan Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 656	Continued From page 6 pencils and coloring pages on 2/05/24. The MDS Nurse stated she did not review the MDS admission assessment for the activity preferences to create a person-centered care plan for Resident #5, but stated she recalled Resident #5 enjoyed coloring in the past. An interview was conducted with the Administrator on 2/07/24 at 2:47 pm who revealed the MDS Nurse was responsible for Resident #5's activity care plan. The Administrator stated Resident #5's care plan interventions should have been added when the care plan was created.	F 656		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		3/7/24

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F 755	Continued From page 7 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain an accurate count of a controlled antianxiety medication for 1 of 4 residents observed for controlled substance administration (Resident #56). Findings included: Review of Resident #56's February 2024 Medication Administration Record (MAR) revealed he received alprazolam 1 milligram (mg) at 8:00 AM, 12:00 PM and 4:00 PM daily. A medication administration observation was conducted on 2/07/24 at 8:20 AM with Nurse #2. The nurse verified Resident #56's medications, opened the locked narcotic box and retrieved Resident #56's alprazolam 1 mg tablets. The individual tablets were in a blister pack with each tablet numbered. Upon removal from the box, the blister pack showed there were 19 tablets. Nurse #1 removed one tablet and showed there were 18 tablets remaining in the blister pack. At the time of the observation a review of Resident #56's Controlled Substance Count	F 755	F755 Pharmacy Services/Procedures/Pharmacist/Records Resident #56's narcotic count sheet was signed and corrected by Nurse #2. All controlled substances for Resident #56 have been signed off on the appropriate narcotic count sheet. On 2/8/2024, the Director of Nursing (DON) initiated an audit of all narcotic count sheets. This audit is to ensure a secured and effective system to contain and record control drugs being administered to a resident was in place, the Nurse and Medication Aide followed facility protocol when administering medications to include signing out controlled substances. The DON will address any concerns identified during the audit. Audit will be completed by 3/7/2024. On 2/8/2024, the DON initiated an in-service with all Nurses and Medication aides regarding Medication Disposition Guidance with emphasis on the process of maintaining narcotic declining sheet -	

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F 755	Continued From page 8 Record for alprazolam 1 mg was completed with Nurse #2. There was a line for each tablet's administration documentation which included the quantity, date, time, amount given, amount left, and a space for the nurse's signature. The previous notation indicated there had been 20 tablets remaining in the blister pack. Nurse #2 was observed writing on the next line of the Controlled Substance Count Record that there had been quantity 19 tablets, and the amount left was 18 tablets. The Shift-Change Controlled Substance Count Check form was noted as signed as completed on 2/06/24 at 7:00 PM and again on 2/07/24 at 7:00 AM, both counts had been conducted by Nurse #2 and Nurse #3. On 2/07/24 at 8:21 AM Nurse #2 was asked about the Controlled Substance Count Record discrepancy indicating there were 20 tablets remaining on the previous line, and after removing 1 tablet there were now 18 left. He explained when he and Nurse #3 counted the controlled substances on 2/06/24 at 7:00 PM and again on 2/07/24 at 7:00 AM the count was correct. He then took the blister pack and the Controlled Substance Count Record to the Director of Nursing (DON). A phone interview with Nurse #3 was conducted on 2/07/24 at 7:17 PM. Nurse #3 stated she had counted the controlled medications twice with Nurse #2 when she was starting her shift on 2/06/24 at 7:00 PM and again on 2/07/24 when she was ending her shift. She explained they looked at both the blister pack card and the Controlled Substance Count Record for each medication to make sure the numbers were	F 755	and administration of controlled substances via each medication's administration documentation count sheet to include the quantity, date, time , amount given, amount left and space for Nurse's and Medication Aide's signature. This in-service will be completed by 3/7/2024. After 3/7/2024, any Nurse or Medication Aide who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired Nurses and Medication Aides will be in-serviced during orientation regarding Medication Disposition Guidance. The RN Unit Manager will audit declining narcotic count sheets to include the quantity, date, time , amount give, amount left and Nurse's and Medication Aide's signature weekly x 4 weeks - then monthly x 1 month utilizing the Narcotic Count Audit Form. This audit is to ensure an accurate, secure and effective system to contain and record control drugs being administered to a resident was in place, the Nurse and Medication Aide followed facility protocol when administering medication to include controlled substances, secure and effective system to contain and record control drugs returning to pharmacy was in place, the Nurse and Medication Aide followed facility protocol when returning medication to include controlled substances. The RN Unit Manager will address all concerns identified during the audit to the completion and accuracy of count sheets for narcotic/controlled medications.	

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F 755	Continued From page 9 correct. She explained she could only think that she did not pay close attention and thought the count had been correct. Nurse #3 stated she could not explain how that medication had been miscounted twice. On 2/07/24 at 8:30 AM the DON reviewed the Controlled Substance Count Record and Resident #56's MAR. She noted the 2/06/24 at 4:00 PM scheduled dose had been signed on the MAR by Nurse #2 but not the Controlled Substance Count Record. She stated she was unsure how the controlled medications could have been counted twice as correct when they were not. On 2/07/24 at 2:38 PM the DON stated it was their process for the on-coming and off-going nurses to count both the controlled substance blister pack cards and sign-off sheets to make sure the numbers match with both nurses looking at and verifying the medications as correct. She explained she would expect controlled substances to be signed out when they were administered.	F 755	The DON will review the Narcotic Count Audit Form weekly x 4 weeks, then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will present the results of the Narcotic Count Audit Form to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet and review the Narcotic Count Audit Form monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 756 SS=D	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	F 756		3/7/24

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F 756	Continued From page 10 facility's medical director and director of nursing, and these reports must be acted upon. (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, staff interviews, Consultant Pharmacist interview, and Medical Director interview, the facility failed to address recommendations made by the Consultant Pharmacist based on the monthly Medication Regimen Review (MRR) for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included:	F 756	F756 Drug Regime Review, Report Irregular, Act on On 2/7/24, the Director of Nursing (DON) clarified with the physician the order for Trazodone for resident #5 and updated the electronic record. Medication was adjusted and prescribed per MD order. On 2/08/24, the Director of Nursing and	

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	345513	A. BUILDING _____ B. WING _____	C 02/08/2024

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F 756	Continued From page 11 The hospital discharge summary dated 10/05/23 revealed Resident #5 was discharged with an order for trazodone (an antidepressant medication) 50 milligram (mg) tablet take 0.5 tablet (25 mg) by mouth nightly for 30 days. Resident #5 was admitted to the facility on 10/05/23 with diagnoses which included major depressive disorder and anxiety. An active physician order entered by Nurse #1 and dated 10/06/23 for trazodone oral tablet 50 mg. Give 1/2 tablet by mouth one time a day for depression; give 25 mg by mouth nightly for depression. The physician order did not have a stop date. A telephone interview was conducted on 2/07/24 at 10:24 am with Nurse #1 who revealed she did not recall entering the trazodone order for Resident #5, but she thought all medication orders were checked by nursing management after admission and would have expected the error to be corrected if needed. Nurse #1was unable to state why the trazodone order was not transcribed correctly for Resident #5. Record review of Resident #5's Consultant Pharmacist's Medication Regimen Review (MMR) dated 10/24/23 revealed the Consultant Pharmacist reported the trazodone was transcribed incorrectly without a stop date. Please correct/clarify. Record review of Resident #5's electronic medication administration records (MAR) revealed Resident #5 received the trazodone medication nightly from 10/06/23 through 2/06/24.	F 756	the Administrator initiated an audit of all pharmacy recommendations for the past 90 days to include pharmacy recommendations for resident #5. This audit is to ensure all pharmacy recommendations are reviewed by the physician and the resident electronic record is updated per physician orders to include but not limited to transcribing stop date orders when indicated to ensure pharmacy recommendations are completed for all residents. All areas of concern will be addressed by the DON to include clarifying physician orders to include stop dates when indicated and updating the electronic record and education of staff. The audit will be completed by 3/7/24. On 2/8/2024, the DON initiated an audit of all newly written orders and admission orders for the past 30 days. This audit is to ensure the nurse transcribed orders accurately to include stop dates when indicated. The DON will address all concerns identified during the audit to include clarifying orders with the physician, updating the electronic medical record with stop dates when indicated and education of staff. The audit will be completed by 3/7/24. On 2/15/24, an in-service was initiated by the Pharmacy Consultant with the DON regarding Pharmacy Recommendations with emphasis on ensuring recommendations to the provider are reviewed and new orders transcribed accurately to the electronic record to	

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F 756	Continued From page 12 An interview was conducted on 2/07/24 at 11:43 am with the Director of Nursing (DON) who revealed the previous Unit Manager was responsible for the Consultant Pharmacist recommendations for Resident #5 to be reviewed and addressed as needed. The DON stated she did not request the MMRs to be returned to her when completed, and she did not check with the previous Unit Manager to ensure the Consultant Pharmacist MMR was addressed. The DON stated she was not aware that the MMR was not addressed prior to this date. The DON stated new admission medication reviews were completed in the morning clinical meeting but that did not include matching the hospital discharge orders to the entered orders for accuracy in transcription. The DON was unable to state how the Consultant Pharmacist recommendation for Resident #5's trazodone was missed for so long. The previous Unit Manager was unavailable for a telephone interview on 2/07/24. A telephone interview was conducted on 2/08/24 at 9:02 am with the Medical Director who revealed she normally reviewed the hospital discharge orders when she confirmed and signed the orders entered by the facility, but she was unable to state how she missed the trazodone order discrepancy from the discharge summary. The Medical Director stated she was not concerned that Resident #5 continued with the trazodone medication, but she stated she did not receive the Consultant Pharmacist recommendation from the facility to review for Resident #5's trazodone medication. An interview was conducted with the	F 756	include but not limited to orders with stop dates. On 2/23/2024, an additional in-service was initiated by the Regional Pharmacy Manager with Nurse Management and Medical Director regarding Pharmacy Recommendations. Pharmacy Recommendations with emphasis on ensuring recommendations to the provider are reviewed and new orders transcribed accurately to the electronic record to include but not limited to orders with stop dates. In-service will be completed by 3/07/24. On 2/7/2024, the RN Unit Manager initiated an in-service with all Nurses regarding Transcribing Physician Orders with emphasis on ensuring orders with stop dates are transcribed accurately to the electronic record and/or clarifying stop date orders when indicated with the Physician. The in-service will be completed by 3/7/24. After 3/7/24, any Nurse who has not worked or received the in-service will complete it at the next scheduled work shift. All newly hired Nurses will be educated during orientation. The DON will audit all pharmacy recommendations monthly x 2 months utilizing the Pharmacy Recommendation Audit Tool to ensure all pharmacy recommendations have been reviewed by the physician and all orders to include orders with stop dates are transcribed accurately to the electronic record. This measure will ensure all pharmacy recommendations are completed for all	

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F 756	Continued From page 13 Administrator on 2/07/24 at 2:42 pm who confirmed she received an email from the Consultant Pharmacist regarding the Medication Regimen Reviews for the facility, but she stated the DON was responsible for the Consultant Pharmacist recommendations. The Administrator was unable to state how the MMR for Resident #5's trazodone order was missed. A telephone interview was conducted on 2/08/24 at 9:09 am with the Consultant Pharmacist who revealed the normal process for the Medication Regimen Review was to send the report via email to the DON and the Administrator of the facility as well as to send a copy in the pharmacy delivery tote to be reviewed and addressed as needed. The Consultant Pharmacist stated they would try to review the previous MMR during the next visit to see if recommendations were acted upon by the facility.	F 756	residents. All areas of concern will be addressed by the DON and/or Nurse Supervisor to include providing recommendations to the provider for review, transcribing orders to the electronic record and/or re-training of staff when indicated. The Administrator will review the Pharmacy Recommendation Audit Tool monthly x 2 months to ensure all areas of concern have been addressed. The Interdisciplinary team to include Minimum Data Set Nurse (MDS), Unit managers, Nurse Supervisors and DON will review all newly written orders 5 times a week x 4 weeks, then monthly x 1 month to ensure all orders to include orders with stop dates were transcribed accurately to the electronic record. The MDS nurse and Unit Manager will address all concerns identified during the audit to include clarifying orders when indicated, updating the electronic record and/or re-training of staff. The DON will review the orders listing report weekly x 4 weeks, then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Pharmacy Recommendation Audit Tool and the Orders Listing Report to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 758	Continued From page 14	F 758		
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; §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	F 758		3/7/24

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F 758	Continued From page 15 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, staff interviews, and Medical Director interview, the facility failed to stop an antidepressant medication prescribed for 30 days which resulted in the resident receiving the medication over the prescribed 30 days for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included: Resident #5's hospital discharge summary dated 10/05/23 revealed an order for trazodone (an antidepressant medication) 50 milligram (mg) tablet take 0.5 tablet (25 mg) by mouth nightly for 30 days. Resident #5 was admitted to the facility on 10/05/23 with diagnoses which included major depressive disorder, anxiety, and schizoaffective disorder. An active physician order dated 10/06/23 for olanzapine (an antipsychotic medication) 5 mg tablet, give 4 tablets at bedtime for schizoaffective disorder.	F 758	F 758 Free of Unnecessary Psychotropic Drugs On 2/6/2024, the order for Trazadone for Resident #5 was discontinued per physician order. On 2/7/2024, the RN Unit Manager under the oversight of the Director of Nursing (DON) initiated an audit of all for residents admitted/re-admitted to the facility in the past 30 days to ensure any medications with a stop order date was transcribed accurately to the electronic medication administration record (MAR). Any identified areas of concern will be immediately addressed by the Director of Nursing to include clarifying the order with the physician and MAR updated when indicated. The audit will be completed by 3/7/2024. On 02/07/2024, the RN Unit Manager initiated an in-service with all nurses and providers regarding Transcribing Orders with emphasis on ensuring stop order	

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F 758	Continued From page 16 An active physician order dated 10/06/23 for escitalopram (an antidepressant medication) 5 mg daily for depression. An active physician order dated 10/06/23 for trazodone oral tablet 50 mg. Give 1/2 tablet by mouth one time a day for depression; give 25 mg by mouth nightly for depression. The physician order did not have a stop date. A telephone interview was conducted on 2/07/24 at 10:24 am with Nurse #1 who entered the trazodone order for Resident #5. Nurse #1 was unable to state why the trazodone order did not include the stop date from the hospital discharge summary for Resident #5. Record review of Resident #5's Consultant Pharmacist's Medication Regimen Review (MMR) dated 10/24/23 revealed the Consultant Pharmacist reported the trazodone was written incorrectly without a stop date. Please correct/clarify. Record review of Resident #5's Consultant Pharmacist's Recommendation dated 1/26/24 revealed a gradual dose reduction (GDR) was recommended for the trazodone order because Resident #5 had been using the medication since 10/06/23. The electronic medication administration records (MARs) were reviewed and revealed the trazodone 25 mg was administered to Resident #5 every night from 10/06/23 through 2/06/24. During an interview on 2/07/24 at 11:43 am with the Director of Nursing (DON), she revealed the new admission medications were reviewed in the	F 758	dates are transcribed accurately when indicated. This in-service will be completed by 3/07/24. After 3/07/24, any nurse or provider who has not been educated will receive the in-service prior to the next scheduled work shift. All newly hired nurses and/or providers will be in-serviced during orientation regarding Transcribing Orders. The Unit Manager will complete an audit of all admissions/re-admission discharge summaries to include Resident #5, utilizing the Admission Order Monitoring tool weekly x4 weeks then monthly x 1 month, to ensure all orders were transcribed accurately to include stop order dates when indicated. Any areas of concern identified during the audit will be immediately addressed by the Unit Manager to include clarifying stop order dates and updating MAR when indicated and/or staff retraining. The Director of Nursing will review the Admission Order Monitoring tool weekly x 4 weeks, then monthly x 1 month for completion. The Administrator will present the findings of the Admission Order Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 758	Continued From page 17 morning clinical meeting but that did not include matching the hospital discharge orders to the entered orders for accuracy. The DON was unable to state how the stop date for Resident #5's trazodone was missed for so long. The previous Unit Manager was unavailable for a telephone interview on 2/07/24. A telephone interview was conducted on 2/08/24 at 9:02 am with the Medical Director who revealed Resident #5 required the trazodone when she was admitted to the facility because the change of environment was a difficult adjustment and the trazodone helped to calm her. The Medical Director stated she reviewed the hospital discharge summary orders before she signed the facility orders to ensure they were entered accurately, but she stated she missed that the order did not have the stop date. The Medical Director stated she did not receive the Consultant Pharmacist recommendation from the facility regarding the incorrect transcription with no stop date for Resident #5's trazodone order. The Medical Director reported she completed a gradual dose reduction (GDR) recommendation from the Consultant Pharmacist Recommendation on 2/07/24 for Resident #5's trazodone.	F 758		
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	F 761		3/7/24

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F 761	Continued From page 18 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to 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 record review, observations, and staff interviews, the facility failed to refrigerate medications according to manufacturer's recommendations for 1 of 1 medication refrigerators located in the Medication room. Findings included: The manufacturer's recommendations for Insulin glargine, insulin degludec and Humulin R recommended that insulin be stored in a refrigerator at approximately 36 to 46 [degrees Fahrenheit] to avoid freezing. On 2/07/24 at 1:45 PM the Medication Room was observed with Nurse #4. The medication top-freezer refrigerator was observed with a secured lock on the refrigerator section.	F 761	F761 Label/Store Drugs and Biologicals On 2/07/24, the DON immediately removed and discarded 1- Insulin glargine 10 milliliters (ml) multi-dose vial unopened; 2- Insulin glargine 3 mL injection pens; 2- Insulin degludec 3mL injection pens; 2- Insulin dulaglutide 0.5 ml injection pens; 3- Humulin R 10 mL multi-dose vials unopened from the facility□s medication storage room freezer. All items were re-ordered for each identified resident. On 2/07/24, DON initiated an audit of all medication storage rooms. This audit is to ensure all medications that require refrigeration to include but not limited to	

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F 761	Continued From page 19 Inside the top-freezer was a white plastic basket containing: 1- Insulin glargine 10 milliliters (ml) multidose vial unopened 2- Insulin glargine 3 ml injection pens 2- Insulin degludec 3 ml injection pens 2- Insulin dulaglutide 0.5 ml injection pens 3- Humulin R 10 ml multidose vials unopened On 2/07/24 at 1:47 PM Nurse #4 stated the insulins should not have been placed into the freezer. Nurse #4 explained the refrigerator was kept locked due to controlled substances which required refrigeration. She further explained the hall nurses each had a key to the Medication Room but only the 100-Hall nurse had the key to the medication refrigerator. On 2/07/24 at 2:38 PM an interview with the Director of Nursing (DON) was conducted. She stated she stated she was unsure who would place insulin into the freezer and not the refrigerator. She explained insulin should not be frozen and would expect the nurses to store the insulin as directed. On 2/08/24 at 8:57 AM an interview with the Administrator was conducted. She stated insulin should be stored at the proper temperature.	F 761	insulin and insulin pens are being stored in the refrigerator at appropriate temperatures to avoid freezing and according to the manufacturer□s instructions. The DON will address all concerns identified during the audit to include discarding any medications not stored at appropriate temperatures, replacing medication when indicated and education of staff. This audit will be completed by 3/07/24. On 2/07/24, the RN Unit Manager initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on ensuring all medications that require refrigeration to include but not limited to insulin and insulin pens are being stored in the refrigerator at appropriate temperatures to avoid freezing and according to the manufacturer□s instructions. In-service will be completed by 3/07/24. After 3/07/24, any nurse or medication aide who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses and medication aides will be in-service during orientation regarding Medication Storage. The Unit Managers will audit all medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. The audit is to ensure all medications that require refrigeration to include but not limited to insulin and insulin pens are being stored in the refrigerator at appropriate	

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F 761	Continued From page 20	F 761	temperatures to avoid freezing and according to the manufacturer□s instructions. All identified areas of concern were addressed by the Unit Managers during the audit to include discarding any medications not stored at appropriate temperatures, replacing medication when indicated and re-training staff. The Director of Nursing (DON) will review the Medication Audit Tool weekly x 4 weeks then monthly x 1 month. The Director of Nursing will forward the results of Medication Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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	F 867		3/7/24

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F 867	Continued From page 21 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: (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	F 867		

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	345513	A. BUILDING _____ B. WING _____	C 02/08/2024

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F 867	Continued From page 22	F 867		

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 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

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F 867	Continued From page 23 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Medical Director interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 8/27/21 recertification and complaint investigation survey and the 10/15/22 recertification and complaint investigation survey. This was for 5 recited deficiencies on the current recertification and complaint investigation survey of 2/08/24 in the areas of Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plan (F656), Pharmacy Services/Procedures/Pharmacist/Records (F755), Free from Unnecessary Psychotropic Medications (F758), and Label/Store Drugs & Biologics (F761). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.	F 867	F867 QAPI/QAA Improvement Activities On 2/09/24, the Facility Consultant initiated an audit of previous citations and action plans from 8/2021 to present related to F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan, F755 Pharmacy Services, F758 Free from Unnecessary Psychotropic Medications, and F761 Label/Store Drugs & Biologics to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the	

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F 867	Continued From page 24 The findings included: This tag is cross-referenced to: F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of Pre-Admission Screening and Resident Review (PASRR) for 2 of 19 sampled residents whose MDS were reviewed (Resident #56 and Resident #23). During the 8/27/21 recertification and complaint investigation survey the facility failed to accurately code the Minimum Data Set (MDS) assessment. During the 10/15/22 recertification and complaint investigation survey the facility failed to accurately code the smoking status of a resident on a Minimum Data Set (MDS) assessment. An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the facility monitored each section of the MDS assessments for accuracy, but the PASRR information was a slight oversight on the part of the facility. F656: Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to develop a person-centered care plan for 1 of 1residents reviewed for activities (Resident #5). During the 10/15/22 recertification and complaint investigation survey the facility failed to develop and implement an individualized person-center care plan.	F 867	education of staff. Audit will be completed by 3/7/24. On 2/09/24, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Unit Managers regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include updated advance directives. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 3/7/24. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan, F755 Pharmacy Services , F758 Free from Unnecessary Psychotropic Medications, and F761 Label/Store Drugs & Biologics, will be taken to the Quality Assurance committee for review monthly x 3 months by the Quality Assurance Nurse. The Quality Assurance committee will review the data and determine if a plan of corrections is being followed, if changes in plans of action are required to improve	

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F 867	Continued From page 25 An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the care plans were reviewed and updated by the interdisciplinary team (IDT). The Administrator was unable to state how the care plan was missed. F755: Based on observation, record review and staff interviews, the facility failed to maintain an accurate count of a controlled antianxiety medication for 1 of 4 residents observed for controlled substance administration (Resident #56). During the 10/15/22 recertification and complaint investigation survey the facility failed to establish a secured and effective system to contain and record control drugs to be returned to the pharmacy for a discharge resident. During an interview on 2/08/24 at 10:30 am the Administrator stated the facility had completed audits of the medication carts, but she was unable to state how the oversight occurred. F758: Based on record review, staff interviews, and Medical Director interview, the facility failed to stop an antidepressant medication prescribed for 30 days which resulted in the resident receiving the medication over the prescribed 30 days for 1 of 5 residents reviewed for unnecessary medications (Resident #5). During the 8/27/21 recertification and complaint investigation survey the facility failed to obtain a stop date for an as needed (prn) antipsychotic medication.	F 867	outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan, F755 Pharmacy Services , F758 Free from Unnecessary Psychotropic Medications, and F761 Label/Store Drugs & Biologics and all current citations and that the QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and Unit Managers for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Director of Nursing to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

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F 867	Continued From page 26	F 867		

During the 10/15/22 recertification and complaint investigation survey the facility failed to implement a 14-day stop date for an as needed psychotropic medication.

An interview was conducted with the Administrator on 2/08/24 at 10:30 am who revealed the normal process was for the IDT team to discuss and review all orders and pharmacy recommendations. The IDT team had completed audits to ensure the identified areas were completed but this was somehow missed during their review.

F761: Based on record review, observations, and staff interviews, the facility failed to refrigerate medications according to manufacturer's recommendations for 1 of 1 medication refrigerators located in the Medication room.

During the 8/27/21 recertification and complaint investigation survey the facility failed to label an open vial of insulin on one of three medication carts reviewed, and the facility failed to affix the locked narcotic box to the refrigerator in one of one medication rooms reviewed.

During the 10/15/22 recertification and complaint investigation survey the facility failed to date two opened medications for 1 of 2 medication carts used for medication administration and failed to store medication in a locked cabinet.

An interview was conducted on 2/08/24 at 10:30 am with the Administrator who revealed the facility had diligently checked medication rooms and carts daily and she was unable to state how the oversight occurred.

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F 883	Continued From page 27	F 883		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		3/7/24

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F 883	Continued From page 28 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents reviewed for immunizations (Resident #65 and Resident #69). The findings included: The facility policy for Immunizations last revised on 10/2/20 read in part "Pneumococcal Immunization: Residents will be offered the immunization upon admission, unless it is medically contraindicated or the resident has already been immunized, and the resident or the resident's representative refuses after receiving appropriate education and consultation regarding the benefits of pneumococcal immunization. Upon consent, the pneumococcal vaccine will be given according to the Centers for Disease Control and Prevention and Advisory Committee	F 883	F883 Influenza and Pneumococcal Immunizations On 2/13//24, the Director of Nursing (DON) educated Resident #65 on the risk and benefits of receiving/declining the pneumococcal vaccine. The DON updated the resident electronic record of education and preference for receiving vaccines. Resident #65 received the influenza vaccine on 2/13/2024 and the pneumococcal vaccine on 2/13/2024 On 2/14/2024, the Nurse Supervisor educated Resident #69 on the risk and benefits of receiving/declining the pneumococcal vaccine. The Nurse Supervisor updated the resident electronic record of education and preference for receiving vaccines. Resident #69 receive	

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F 883	Continued From page 29 for Immunization Practice recommendations." a. Resident #65 was admitted to the facility on 12/28/23 with a diagnosis of chronic kidney disease. The Minimum Data Set (MDS) admission assessment dated 1/2/24 revealed Resident #65 was not up to date with the pneumococcal vaccine and that it was offered and declined. Review of Resident #65's admission packet revealed Resident #65 gave authorization for the pneumococcal vaccine to be administered. Review of Resident #65's immunization record on 2/6/24 revealed no documentation that the pneumococcal vaccine was administered. Review of a health status note dated 2/6/24 revealed that Resident #65 was offered the pneumococcal vaccine, and he declined. An interview was conducted with the Infection Preventionist/Director of Nursing on 2/07/24 at 1:14 PM. She stated that the policy states that the pneumococcal immunization should be offered upon admission if it was not previously received. The Admissions Director reviewed consent for immunizations during the admission process, and the interdisciplinary team (IDT) meeting should follow-up on the resident's response. The floor nurse or unit manager were responsible to administer the vaccine. The Infection Preventionist/Director of Nursing stated that the information for Resident #65 should have been forwarded to the IDT to ensure the vaccines were administered.	F 883	the pneumococcal vaccine on 2/14/24 per preference and the electronic record was updated. On 2/12/2024, the Administrator initiated an audit of Influenza and Pneumonia immunizations for all current residents. This audit was to identify any resident who had not been provided the Influenza or Pneumonia vaccine or have a documented refusal of immunization per facility protocol, to ensure residents/resident representative were educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record and that appropriate consent obtained prior to administering vaccines. The DON/Nurse Manager will address all concerns identified during the audit to include education of the resident/resident representative of risks/benefits of receiving/refusing of vaccine with documentation in the electronic record, obtaining appropriate consent, providing vaccine per resident preference and/or education of staff. Audit will be completed by 3/07/2024. On 2/16/2024, the Nurse Supervisor initiated an in-service with all Nurses regarding Immunizations. Emphasis is on educating resident/resident representative on the risks/benefits or receiving/refusing vaccines, obtaining appropriate consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record	

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F 883	Continued From page 30 During an interview with the Administrator on 2/7/24 at 11:10 AM, she revealed that Resident #65 accepted the pneumococcal vaccine when completing the consent/release form within the admissions packet. She stated that she was uncertain what happened after he was admitted, but if he accepted the vaccine then it should have been administered. b. Resident #69 was admitted to the facility on 6/23/23 with a diagnosis of diabetes. The Minimum Data Set (MDS) quarterly assessment dated 1/8/24 revealed Resident #69 was not up to date with the pneumococcal vaccine and that it was not offered. Review of Resident #69's admission packet revealed Resident #69 gave authorization for the pneumococcal vaccine to be administered. Review of Resident #69's immunization record on 2/6/24 revealed no documentation that the pneumococcal vaccine was administered. An interview was conducted with the Infection Preventionist/Director of Nursing on 2/07/24 at 1:14 PM. She stated that the policy states that the pneumococcal immunization should be offered upon admission if it was not previously received. The Admissions Director reviewed consent for immunizations during the admission process, and the interdisciplinary team (IDT) meeting should follow-up on the resident's response. The floor nurse or unit manager were responsible to administer the vaccine. The Infection Preventionist/Director of Nursing stated that the information for Resident #69 should have been forwarded to the IDT to ensure the vaccines were	F 883	and/or documentation of resident refusal if vaccine declined. In-service will be completed by 03/07/2024. After 03/07/2024, any nurse who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Immunizations. The Unit Manager will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks/benefits of receiving/refusing Influenza and Pneumonia vaccines, appropriate consent and physician order for vaccine obtained prior to administering vaccine, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The Unit Manager will address all concerns identified during the audit. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 883	Continued From page 31 administered. During an interview with the Administrator on 2/07/24 at 11:07 AM, she revealed that the admitting nurse and Admissions Director offer consent for the pneumococcal vaccine. The Administrator stated she why Resident #69 did not receive the vaccine after he had consented. If Resident #69 consented to the pneumococcal vaccine upon admission, then the vaccine should have been provided.	F 883		