STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

(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 were conducted on 04/29/24 through 05/02/24. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID: 7W9D11.	E 000		
F 000	INITIAL COMMENTS A recertificiation and complaint survey was conducted on 04/29/24 through 05/02/24. Event ID# 7W9D11. The following intakes were investigated: NC00212089, NC00211922, NC00208601, and NC00207309. 8 of 8 complaint allegations did not result in a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Resident interviews the facility failed to assess the resident for the ability to self-administer medications for 1 of 1 resident (Resident #25) reviewed for self-administration of medication. The findings included: Resident #25 was admitted to the facility on 10/14/21. A review of Resident #25's physician orders revealed an order dated 04/01/23 for Fluticasone	F 554	On 5/1/24 Facility assessed resident #25's ability to self-administer medications. Orders obtained for medications to be self-administered and care plan was updated. Facility staff conducted visual observations and verbal interviews to ensure policy and procedures for self-administration of medications is met. Any identified concern were addressed with the appropriate assessment, care plan and orders. Audit completed on	5/20/24

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

Electronically Signed | 05/17/2024

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F 554	Continued From page 1 Propionate Nasal Suspension 50 micrograms per activation (mcg/act) 2 sprays, in both nostrils one time a day for allergies. The order did not include the Resident could self-administer the medication. A further review of Resident #25's physician orders revealed there were no orders for over the counter pain patches or an albuterol sulfate inhaler. There was no Self Administration assessment for an inhaler or pain patch. A review of Resident #25's quarterly Minimum Data Set assessment dated 01/25/24 revealed she was cognitively intact. A review of Resident #25's medical record revealed a Self-Administration assessment dated 04/18/24 that indicated the Resident was mentally and physically able to self-administer the Fluticasone Nasal Spray. The assessment was completed by Nurse #1. On 04/29/24 at 4:06 PM an observation and interview were conducted with Resident #25 in her room. On the Resident's over bed table was a bottle of Fluticasone Nasal Spray that the Resident explained she used every day for her allergies. Resident #25 also had a pain patch on her right knee, and she explained that she kept them in her cabinet and only used it when she had pain in her knee. The Resident removed a box of over the counter pain patches to show there were two remaining in the box. Resident #25 explained that she also had an inhaler in her purse that she used when she needed to and produced an Albuterol Sulfate inhaler.	F 554	5/16/24 by DON/Designee. Nurses and Med Aides were educated on the self-administration of medication policy and procedure. Education will be ongoing for all newly hired nurse, medication aide and C.N.A. Education Completed on 5/17/24 by DON/Designee. To ensure policies and procedures of self-administration of medications are met, an audit will be completed 8 residents a week for 12 weeks to ensure no medications are left at bedside without a proper order, assessment and care plan. Audit to be completed by DON/Designee and trends to be reviewed in QAPI.	

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F 554	Continued From page 2 During an interview with Resident #25 on 04/30/24 at 8:56 AM the Resident explained again the use of the nasal spray which was sitting on her over bed table, the pain patch and the inhaler and stated they were still in her room. An interview was conducted with Nurse #1 on 04/30/24 at 3:02 PM. The Nurse explained that she remembered assessing Resident #25's ability to administer her nasal spray but stated she took the nasal spray to the Resident in the morning when she gave her morning medications to her and allowed the Resident to administer the nasal spray. Nurse #1 stated she was not aware that the Resident kept pain patches and an inhaler in her room and stated she did not have an order for them. She indicated she would need to obtain an order for the inhaler and pain patches and assess her ability to administer them. During an interview with the Director of Nursing (DON) on 04/30/24 at 3:12 PM she explained that the Resident should have been assessed for the ability to self-administer every medication that she kept in her room and there needed to be an order for that medication as well. The DON also stated the staff needed to be educated to monitor medications at the Residents' bedside.	F 554		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		5/20/24

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§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

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F 636	Continued From page 4 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAAs) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 5 sampled residents (Residents #67 and #32). The findings included: Resident #67 was admitted to the facility on 01/10/24 with diagnosis that included depression. Review of a physician order dated 01/11/24 read; Fluoxetine HCL (antidepressant) 10 mg by mouth every day for depression. Review of the comprehensive admission Minimum Data Set (MDS) dated 01/16/24 revealed Resident #67 was cognitively intact and had no behaviors, rejection of care, or wandering and no signs of delirium were noted during the assessment reference period. The MDS indicated that Resident #67's diagnosis included depression and that he had taken an	F 636	On 5/14/24 the Care Area Assessment (CAAs) was complete for resident #67 to describe the resident psychosocial needs, behaviors, medications and how these psychosocial needs will be met. On 5/14/24 the CAA was complete for resident #32 to describe the residents problems, possible causes, and contributing factors, risk factors, related to the care area and reasoning to proceed to care planning. All resident have the potential to be affected therefore on 5/17/24, the Minimum Data Set Coordinator reviewed all CAAs for previous 30 days. Noted findings were addressed with appropriate documentation. Education complete by Regional Clinical Reimbursement Specialist on 5/16/24 to facility Minimum Data Set Coordinator (MDSC) to ensure the facility MDSC complete CAAs to address underlying	

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antidepressant during the assessment reference period.

Review of the triggered Care Area Assessment (CAA) worksheet for Psychosocial wellbeing dated 01/23/24 had the following boxes checked: resident says or indicated they feel lonely and indicted that Resident #67 had diagnosis of depression. Health status factors that may inhibit social involvement had the following boxes checked: decline in functional abilities, mood or behavior problem, health problems such as fall, and change in communication. The nature of the problem contained no information describing Resident #67's psychosocial needs, behaviors, medications, or how the facility would address and meet Resident #67's psychosocial needs. The care plan decision was made to proceed. The CAA was completed by MDS Nurse #1.

MDS Nurse #1 was interviewed via phone on 05/02/24 at 9:47 AM. MDS Nurse #1 explained that when completing the CAA, she gathered the information from what she used to complete the MDS assessment, which included chart review, therapy notes, and doctor notes. Once the information was gathered, she would go into the CAA and check any applicable boxes and then make the care plan decision and develop the care plan. MDS Nurse #1 was asked if she had had ever been told that she needed to thoroughly assess each resident and their condition that was applicable to each CAA that triggered, she replied, "I honestly felt like stating to proceed and then addressing it in the care plan was sufficient enough" and that was why she did not further elaborate in the CAA.

The Director of Nursing (DON) was interviewed

causes and triggered areas. New MDSC will be education upon hire.

Audit to be completed on 10 resident comprehensive assessments a week for 12 weeks to ensure CAAs are complete comprehensively and accurately. Audit to be completed by DON/Designee and trends to be reviewed in QAPI.

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on 05/02/24 at 3:16 PM. She stated that she would expect the CAA to be comprehensive and thorough and give the appropriate information to paint a picture of the resident, their condition, and their identified needs.

2. Resident #32 was admitted to the facility on 04/01/20 with diagnoses that included Alzheimer's disease, dementia, amnesia, mood disturbance and psychotic disorder.

A review of Resident #32's significant change Minimum Data Set (MDS) assessment dated 08/01/23 revealed the Resident's cognition was coded as moderately impaired. A review of section V of the MDS (care areas triggered for assessment to indicate need for care plan) revealed the care area of psychotropic drug use was triggered but the facility did not include information in the analysis of findings that described the Resident's problems, possible causes and contributing factors, risk factors related to the care area and reasons to proceed to care planning.

A review of Resident #32's medical record revealed the last gradual dose reduction of antipsychotic medication was 08/23/23 for Risperdal 1 milligram (mg) by mouth once a day to 0.5 mg by mouth once a day for psychotic disorder.

A review of Resident #32's quarterly MDS dated 01/29/24 revealed her cognition was moderately impaired and she had no behaviors or rejection of care. The MDS also indicated Resident #32 received an antipsychotic medication.

A review of Resident #32's April Medication

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Administration Record for 04/2024 revealed the Resident received a daily antipsychotic medication.

On 05/01/24 at 4:57 PM during an interview with the Psychiatric Nurse Practitioner (NP) the NP explained that she routinely visited with Resident #32 for auditory hallucinations and paranoia in that someone was trying to "get to her". She continued to explain that the Resident required an antipsychotic medication that in the past the gradual dose reductions had failed and recently (08/23/23) the medication was reduced again. She indicated she would continue to consult with the Resident.

MDS Nurse #1 was interviewed via phone on 05/02/24 at 9:47 AM. MDS Nurse #1 explained that when completing the CAA, she gathered the information from what she used to complete the MDS assessment, which included chart review, therapy notes, and doctor notes. Once the information was gathered, she would go into the CAA and check any applicable boxes and then make the care plan decision and develop the care plan. MDS Nurse #1 was asked if she had had ever been told that she needed to thoroughly assess each resident and their condition that was applicable to each CAA that triggered, she replied, "I honestly felt like stating to proceed and then addressing it in the care plan was sufficient enough" and that was why she did not further elaborate in the CAA.

An interview was conducted with the Director of Nursing (DON) on 05/02/24 at 3:16 PM. The DON explained that she expected the care area assessments to be comprehensive and thorough and give the appropriate information to paint a

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F 636	Continued From page 8 picture of the residents, their condition and their identified needs. During an interview with the Social Worker (SW) on 05/02/24 at 3:22 PM the SW explained that Resident #32 was seen by psychiatric services because she was refusing to take her medications and started to be fixated on her roommate and would not let the staff in her room. She indicated the Resident was stable at present and psychiatric services would continue.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial 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	F 656		5/20/24

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F 656	Continued From page 9 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews the facility failed to develop a care plan that included an area of focus for a urinary catheter for 1 of 3 residents (Resident #17) reviewed for urinary catheters. The finding included: Resident #17 was admitted to the facility on 12/10/21 with a cumulative diagnosis including urinary retention. A review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated 02/05/24 revealed the Resident's cognition was moderately impaired and she was always incontinent of urine. The MDS was coded as not having an indwelling	F 656	On 5/2/24 resident #17 care plan was updated to ensure proper care planning of a catheter. There was no negative outcome. All residents have the potential to be affected therefore on 5/15/2024, the Director of Nursing reviewed all residents with catheters to ensure appropriate catheter care plans. There were no other negative findings. To prevent this from reoccurring again, on 5/15/24 the Regional Clinical Reimbursement Specialists completed education on accuracy of care plans, specifically related to ensure resident with	

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F 656	Continued From page 10 urinary catheter. A review of Resident #17's care plan last reviewed on 04/24/24 revealed there was no care plan for a urinary catheter. A review of a Urology consult dated 04/12/24 revealed a #16 urinary catheter with 10 cubic centimeters (cc) was inserted into the bladder for significant history of Parkinson Disease, urinary infections, incontinence of bladder and bowel and immobility. Change urinary catheter monthly at nursing facility. A review of Resident #17's physician orders dated 04/17/24 revealed orders for a) urinary catheter, b) change catheter as needed (prn), c) stabilizing device, d) privacy bag, e) catheter care and f) keep catheter below bladder. An interview was conducted with Minimum Data Set (MDS) Nurse #2 on 05/02/24 at 9:00 AM. The Nurse explained that her coworker (MDS Nurse #1) normally attended the clinical meetings in the morning and would have been the MDS Nurse who should have initiated a care plan for Resident #17's urinary catheter but MDS Nurse #1 was out on leave, so the care planning was up to her. MDS Nurse #2 stated that she did not know that Resident #17 had a urinary catheter placed. Attempts were made to interview MDS Nurse #1, but the attempts were unsuccessful. On 05/02/24 at 2:37 PM during an interview with the Director of Nursing (DON) she stated Resident #17 went for a urology consult and came back with a urinary catheter. The DON explained that the catheter should have been care planned.	F 656	catheters have appropriate care planning. New MDSC will be education upon hire. The MDS Coordinator or designee will audit 10 random charts weekly for 12 weeks, to ensure proper documentation of catheters. All audits will be reported to the QAA Committee for three months or until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and	F 690	Resident #11 bed height was immediately	5/20/24

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F 690	Continued From page 12 interviews, the facility failed to prevent urinary catheter bags from touching the floor for 2 of 3 residents (Resident #11 and Resident #17) reviewed for urinary catheters. The findings included: 1. Resident #17 with a cumulative diagnosis that included urinary retention. A review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated 02/05/24 revealed the Resident's cognition was moderately impaired and she was always incontinent of urine. The MDS was also coded as not having an indwelling urinary catheter. A review of Resident #17's care plan revealed there was no care plan for a urinary catheter. A review of a Urology consult dated 04/12/24 revealed a #16 urinary catheter with 10 cubic centimeters (cc) was inserted into the bladder for significant history of Parkinson Disease, urinary infections, incontinence of bladder and bowel and immobility. Change the urinary catheter monthly at nursing facility. A review of Resident #17's physician orders dated 04/17/24 revealed orders for a) urinary catheter, b) change catheter as needed (prn), c) stabilizing device, d) privacy bag, e) catheter care and f) keep catheter below bladder. Multiple observations were made during the survey of Resident #17's urinary catheter bag positioned on the floor. The observations were as noted:	F 690	adjusted to safe height to ensure catheter bag does not touch the floor. Resident #17 catheter bag was immediately adjusted to prevent bag from touching the floor when in her w/c. Residents with Catheters were audited to ensure catheter bags were not touching the floor. Identified concerns immediately corrected and fixed so that the catheters do not touch the floor. Audit completed on 5/17/24 by DON/Designee. Nursing staff educated on ensuring catheter bags are positioned to prevent them from touching the floor when in bed or w/c. Education completed on 5/17/24 by DON/Designee. New nursing staff will be education upon hire. Audit to be completed on 8 Residents with catheters a week x's 12 weeks to ensure Catheter bags are not touching the floor. Audit to be completed by DON/Designee and trends to be reviewed in QAPI.	

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-04/30/24 at 12:00 PM Resident #17 was sitting in the dining room in her wheelchair with the catheter bag mounted under the wheelchair and the catheter bag was positioned on the floor. Multiple staff were observed walking around in the dining room.

-04/30/24 at 12:27 PM Resident #17 was sitting in the dining room in her wheelchair with the catheter bag positioned on the floor. Multiple staff were observed walking around in the dining room.

-04/30/24 at 12:57 PM Resident #17 remained in the dining room sitting in her wheelchair. Multiple staff walked by the Resident while the catheter bag was positioned on the floor.

-04/30/24 at 3:32 PM Resident #17 was observed sitting in her wheelchair in the activity room with staff present. The catheter bag was mounted under the wheelchair and the catheter bag was positioned on the floor.

05/01/24 10:55 AM Resident #17 was observed in her room sitting in her wheelchair with the catheter bag mounted under the wheelchair and positioned on the floor.

05/01/24 at 11:09 AM accompanied staff into the Resident #17's room for interview and observation of the transfer of Resident #17 being put into bed by Nurse Aide (NA) #1 and NA #2. Both NAs noted the Resident's catheter bag positioned on the floor under the wheelchair. NA #1 explained that she mounted the catheter bag under the wheelchair because she did not have anywhere else to attach it. The NA continued to explain that it was not touching the floor when she hung it there and stated it should not be on the

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floor because it could cause infection.

05/01/24 at 11:13 AM An interview was conducted with Nurse #5 who was assigned to care for Resident #17 on 05/01/24. The Nurse explained that she did not know the specific reason for Resident #17's catheter but she did know that Resident #17 went for a urology consult last week (04/12/24) and came back with the catheter. She stated the Resident had numerous complaints of burning on urination and was tested monthly for urinary tract infections. Nurse #5 also explained that the catheter bag should not be on the floor due to the potential for infection. She stated that she did not notice the catheter bag was on the floor when she worked with her, but she stated she did not specifically look for it either.

On 05/02/24 at 2:37 PM during an interview with the Director of Nursing (DON) she stated Resident #17 went for a urology consult and came back with a urinary catheter. She stated the catheter bag should not be positioned on the floor for infection control reasons.

2. Resident #11 was admitted to the facility on 08/17/22 with diagnoses that included presence of urogenital implants, history of urinary tract infections, history of falling and urinary retention.

Review of Resident #11's quarterly Minimum Data Set assessment dated 02/28/24 revealed her to be cognitively intact without delirium, behaviors, or rejection of care. Resident #11 was coded as not having a catheter at the time and was occasionally incontinent of bladder and always continent of bowel.

An observation of Resident #11 on 04/29/24 at

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12:19 PM revealed her to be in her room, in bed resting. Resident #11's catheter bag was observed to be ¾ full and resting on the floor causing the bag to fold in on itself.

Another observation of Resident #11 was completed on 04/30/24 at 11:51 AM. Resident #11 was observed to be in her room, in bed asleep. Resident #11's catheter bag was observed to be laying flat on the floor due to her bed being placed in the lowest possible position.

An interview with NA #4 on 04/30/24 at 12:31 PM revealed she had been assigned to Resident #11 on 04/29/24 and 04/30/24. She reported Resident #11 required to be kept with her bed in the lowest position due to her being a fall risk. She reported she was aware Resident #11 had a catheter and indicated resident's catheter bag being on the floor was due to her having to be in the lowest position. NA #4 reported she was aware that the catheter bag would be resting on the floor when Resident #11's bed was placed in the lowest position.

An interview with Nurse #3 on 04/30/24 at 12:40 PM revealed Resident #11 was a fall risk and was required to keep her bed in the lowest position. Nurse #3 also reported that she was aware Resident #11 had a catheter and that Resident #11's bed should be kept in the lowest possible position that prevented the catheter bag from resting on the floor.

An observation of Resident #11 with Nurse #3 completed on 04/30/24 at 12:43 PM revealed Resident #11's catheter bag resting on the floor. Nurse #3 reported the catheter bag would occasionally come into contact with the floor due

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F 690	Continued From page 16 to Resident #11 having to be in a low bed but there had been no issues with Resident #11's catheter and the output was still good. Nurse #3 ultimately raised Resident #11's bed to ensure the catheter bag was not in contact with the floor. During an interview with the Director of Nursing on 05/02/24 at 1:36 PM she reported she was familiar with Resident #11 and was aware she had a catheter. The Director of Nursing reported that catheter bags should never come into contact with the floor and if a resident was required to be kept in a low bed, then the bed should be kept in the lowest possible position that prevented the catheter bag from touching the floor. An interview with the Administrator on 05/02/24 at 2:21 PM revealed he expected catheter bags to not touch the floor. He reported if a resident was required to be in a low bed, then the bed should be low enough to ensure that catheter bags were kept off the floor.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		5/20/24

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F 761	Continued From page 17 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure a controlled substance medication ordered for a resident was safely stored and secured using a double lock feature for 1 of 4 medication storage refrigerators observed (Resident #65). A controlled substance has an accepted medical use, a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The facility also failed to date an open vial of insulin on 1 of 2 medication carts reviewed (300/400 hall medication cart) and failed to date a vial of Tuberculin Serum (used to conduct tuberculosis screening) and failed discard the Tuberculin serum after 30 days in 2 of 4 medication rooms reviewed 300/400 hall medication cart and 500/600 hall medication cart). The findings included: Review of a facility policy titled Storage and Expiration Dating of Medications, Biologicals revised last on 08/07/23 read in part, facility	F 761	Facility immediately secured the controlled medication in a double locked medication fridge on 4/30/24. Undated Insulin was immediately removed and discarded on 4/30/24. Undated and expired Tuberculin was immediately removed and discarded on 4/30/24. On 5/15/24, Director of Nursing audited all Medication fridges to ensure double lock feature were in place. On 5/15/24, Insulins were audited to ensure open date present. On 5/15/24 Tuberculin was audited to ensure date open present and that no vials were expired. All identified concerns were immediately corrected. Regional Director of Clinical Services educated Director of Nursing on 5/17/24 to ensure controlled medications are secured by double lock and key. Nurses/Med aides were educated on storage of controlled substances and on placing date open dates on insulin and	

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F 761	Continued From page 18 should store Schedule II-V controlled substances in a separate compartment within the locked medication carts and should have a different key or access device. Store all drugs and biologicals in locked compartments, including the storage of scheduled II-V medications in separately locked, permanently affixed compartments permitting only authorized personnel to have access. 1. Resident #65 was admitted to the facility on 07/24/23. Review of a physician order dated 04/03/24, Lorazepam (schedule IV antianxiety) 2 milligrams (mg)/1 milliliter (ml), give 0.5 mg by mouth at bedtime for anxiety. An observation of the 700/800 hall medication room refrigerator was made on 04/30/24 at 3:29 PM along with Nurse #1 revealed the small medication room refrigerator did not have a lock device on it. Once opened the refrigerator had a small permanently affixed container but the lock was not present and only contained a small hole where the lock used to be. The permanently affixed container was opened by inserting a finger into the lock hole and opening the container. Inside the container was a box labelled with Resident #65's name and directions. The medication was Lorazepam 2mg/1ml that contained approximately 12 ml of medication in it. The Director of Nursing (DON) was interviewed on 04/30/24 at 3:57 PM. The DON was asked to observe the 700/800 hall medication room refrigerator. She stated that she was unaware that the lock was broken on the refrigerator and on the small permanently affixed container. She stated she was aware that the Lorazepam	F 761	tuberculin containers as well as ensuring tuberculin is destroyed after 30 days of date opened. Education to be completed by DON/Designee on 5/17/24. New nurses and Medication Aides will be educated upon hire. DON/Designee to complete audit on 4 medication carts and 5 medication fridges weekly for 12 weeks to ensure compliance with double lock feature for controlled medications, date open for insulins and Tuberculin and that expired Tuberculin is removed from use. Trends/results are to be reviewed in QAPI.	

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needed to be secured and she would get a lock installed immediately.

Nurse #1 was interviewed on 04/30/24 at 4:10 PM who stated the lock on the medication room refrigerator in the medication room had been broken for months and she had reported it several people but could not recall who all she had reported to. Nurse #1 explained that the lock on the refrigerator had been broken since last week and she had not report that to anyone. She added that the lock that was on the refrigerator was so flimsy and was hanging on by a thread and then eventually just fell off sometime last week.

2. Review of a facility policy titles Storage and Expiration Dating of Medications, Biologicals revised last on 08/07/23 read in part, facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.

An observation of the 300/400 hall medication cart was made on 05/01/24 at 10:00 AM along with Nurse #2. The observation revealed an opened via of Humalog insulin that contained no date of when it was opened.

Nurse #2 was interviewed on 05/01/24 at 10:10 AM, she stated she was not sure when the vial had been opened as she only worked one day a week. She indicated that she would discard the vial of insulin.

The Director of Nursing (DON) was interviewed on 04/30/24 at 3:49 PM, who stated that the third shift staff were expected to go through the

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medication room and carts at least weekly and then of course the nurses should be going through the medication carts on a daily basis as they were medicating residents to ensure that everything was dated and labelled correctly. The DON stated insulin vials were good usually for 28 days after being opened and coming out of the refrigerator and the nurses should be keeping track of the 28 days by dating the insulin vial or pen when it was opened.

The Administrator was interviewed on 05/02/24 at 3:29 who stated that all insulin vials should be dated when they were opened.

3. Review of a facility policy titles Storage and Expiration Dating of Medications, Biologicals revised last on 08/07/23 read in part, facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.

A. An observation of the 500/600 hall medication room refrigerator was made on 04/30/24 at 3:34 PM along with Nurse #3. The observation revealed a vial of Tuberculin serum that was dated as being opened on 03/12/24.

B. An observation of the 300/400 hall medication room refrigerator was made on 04/30/24 at 3:46 PM along with Nurse #4. The observation revealed an opened vial of Tuberculin serum that had no date of when it was opened.

Nurse #4 was interviewed on 04/30/24 at 4:00 PM, she stated she was fairly new to the facility, and she was not sure about the vial of serum and would have to ask the Director of Nursing (DON).

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F 761	Continued From page 21 The DON was asked to observe the 500/600 hall medication room refrigerator and the 300/400 hall medication room refrigerator on 04/30/24 at 3:57. The DON stated she was not aware that the vials of Tuberculin serum were undated and were kept past the 30-day shelf life after opening. The DON again confirmed that the tuberculin serum was good for 30 days after opening and then should be discarded. The Administrator was interviewed on 05/02/24 at 3:29 PM who stated he expected the staff to follow the facility policy and procedures for dating vials of medication and removing them by their use by or expiration date.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on test tray observations, resident, and staff interviews the facility failed to serve food that was palatable in taste for 7 of 7 residents reviewed for food (Resident #25, Resident #26, Resident #30, Resident #47, Resident #77, Resident #124, and Resident #126). This practice had the potential to affect other residents.	F 804	On 5/1/24 Resident #25, #26, #30, #47, #77, #124, and #126 were provided with a meal according to the community menu. To identify others with the potential to be effected, interviews were complete for all alert and oriented residents. Interviews were reviewed by the Food Service	5/20/24

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F 804	Continued From page 22 The findings included: 1a. Resident #25 was admitted to the facility 10/14/21. A review of Resident #25's quarterly Minimum Data Set (MDS) assessment dated 01/25/24 revealed she was cognitively intact and required set up assistance with eating activity. An interview was conducted with Resident #25 on 05/01/24 at 2:50 PM. The Resident was sitting in her wheelchair at her bedside and when asked about her lunch she remarked that they served her beef stir fry, rice and a roll with mango mousse for dessert. The Resident explained that she could not eat the beef stir fry because it was too salty, so she ate the rice, roll and the mousse. The Resident stated she would have to wait until supper to eat again. b. Resident #26 was admitted to the facility on 08/30/18. Review of the quarterly Minimum Data Set (MDS) dated 01/27/24 revealed that Resident #26 was cognitively intact and required set up assistance with eating. An interview was conducted with Resident #26 on 05/01/24 at 1:10 PM. Resident #26 was sitting in his wheelchair on the front porch of the facility. When asked how his lunch was, Resident #26 shook his head and stated, "I could not eat it, it was too salty." When asked if he had eaten anything Resident #26 stated he had not and stated he would be ok until dinner time. c. Resident #30 was admitted 07/08/22.	F 804	Manager and recommendations for this meal were made to facility cook. All Cooks were educated on 5/15/2024 by the Food Service Supervisor to ensure compliance of the Taste Testing Policy and the Standardized Recipe Policy. Newly hired cooks will be educated during on-boarding and orientation. To monitor and maintain compliance the administrator or designee will audit 5 meals per week for 12 weeks to ensure food is palatable. The Administrator or designee will interview 10 residents per week for 12 weeks. Results will be brought to Food Service Committee for review. All audits will be reported to the QAA Committee for three months or until such time consistent substantial compliance has been achieved as determined by the committee.	

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A review of Resident #30's quarterly Minimum Data Set assessment dated 03/15/24 revealed she was cognitively intact, and she required set up assistance with eating activity.

During an interview with Resident #30 on 05/01/24 at 4:10 PM the Resident explained that she was served beef stir fry and rice for lunch, but she could not eat the beef because it was too salty. The Resident stated luckily, they brought her baked chicken, or she would not have eaten any meat until supper.

d. Resident #47 was admitted to the facility on 03/08/23.

A review of Resident #47's quarterly Minimum Data Set assessment dated 03/01/24 revealed her cognition was moderately impaired and she was independent with her eating activity.

During an interview with Resident #47 on 05/01/24 at 4:15 PM the Resident explained that she was given beef stir fry and rice for lunch, but she could not eat the beef stir fry because it was too salty and spicy for her taste. She stated she would have to wait for supper before she would eat again.

e. Resident #77 was admitted to the facility on 03/30/23.

A quarterly Minimum Data Set (MDS) dated 04/07/24 revealed that Resident #77 was cognitively intact and required set up assistance with eating. The MDS also indicated that Resident #77 received a therapeutic diet during the assessment reference period.

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An interview was conducted with Resident #47 on 05/01/24 at 3:01 PM. Resident #47 was up in her wheelchair in her room. She stated, "lunch was terrible, I took a couple of bites, and it was too salty, and I could not take it." Resident #47 stated she had not asked the staff for anything else, she just snacked on some things that that she had in her room to tide her over until dinner.

f. Resident #124 was admitted to the facility on 04/16/24.

The admission Minimum Data Set (MDS) dated 04/22/24 revealed that Resident #124 was cognitively intact and required set up assistance with eating. The MDS further revealed that Resident #124 received a therapeutic diet during the assessment reference period.

An observation and interview were conducted with Resident #124 on 05/01/24 at 3:00 PM. Resident #124 was resting in bed in a gown. She was observed to have a package of pecan wheels on her bedside table and 2 had been eaten. Resident #124 stated she could not eat the beef stir fry because "it was full of salt and then there was clump of rice with no gravy or anything on it. It was terrible." Resident #124 stated she had eaten 2 pecan wheels because "she had to have something to eat all I had for breakfast was a small box of cereal."

g. Resident #126 was admitted to the facility on 04/05/24.

The admission Minimum Data Set (MDS) dated 04/11/24 indicated that Resident #126 was cognitively intact and required no assistance with

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eating.

An observation and interview were conducted with Resident #126 on 05/01/24 at 5:30 PM. Resident #126 was sitting in her wheelchair in room visiting with her family member. There was a cup that had a milkshake in it on her bedside table. Resident #126 stated she could not eat the beef stir fry that was served for lunch because "it was too salty." She stated someone from the facility had brought her some chicken nuggets and her family member had brought her a milkshake so she was full but again stated that lunch was "just too salty," and she could not eat it.

Cook #1 was interviewed on 05/02/24 at 12:24 PM. Cook #1 confirmed that she had prepared lunch on 05/01/24 and confirmed that it was beef vegetable stir fry. She stated that she had prepared the meat on the flat top grill and chopped the meat and vegetables (broccoli, green beans, peas, cauliflower, and red peppers) together. Once the meat was cooked and vegetables chopped, she added the soy sauce. Cook #1 stated that the recipe called for 2 cups of soy sauce for 50 people, and she was preparing for 100 people so added 4.5 to 5 cups of soy sauce. She stated that before she added the soy sauce, she tasted the stir fry and it tasted "perfect," but she had not tasted it after she added the soy sauce. Cook #1 confirmed that the soy sauce was not low sodium and that she thought it was a lot of soy sauce but stated "I thought it would balance out since I was cooking a big portion."

2. An observation of the test tray was conducted on 05/01/24 at 12:46 PM along with the

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F 804	Continued From page 26 Administrator and Dietary Manager (DM). The tray was served on a plate that was enclosed on an insulated plate bottom and covered with an insulated lid. When the lid was lifted off the plate there was visible steam noted. The plate contained a portion of rice and beef stir fry. There was no egg roll or dessert (mango mousse) served with the test tray. The test tray was sampled and noted to be hot, the rice was a bit mushy, and the stir fry was very salty. The DM indicated that the beef stir fry was too salty for her as well but stated that they had followed the recipe that called for 2 cups of soy sauce for 50 people, and they doubled it since they were preparing for 100 people. The Administrator was interviewed on 05/02/24 at 3:36 PM. He stated that the DM had been at the facility since it opened but recently just moved into the manager role. He stated that he had worked with her closely for about a month then that allowed her to take over and run the show. He stated that they were getting some feedback from the residents that required them to take a step back and look at the whole operation of the kitchen. He stated for palatability the kitchen staff were required to send him a picture of the meals and he had accumulated over 200 pictures of the meals that were served to the residents. The Administrator did state that he did not conduct test trays and had not eaten the food at the facility.	F 804		
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	F 867		5/20/24

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policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and 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.

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§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness 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

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F 867	Continued From page 29 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 06/04/21. This failure was for two deficiencies that were originally cited in the areas of Resident Assessment (F636) and Pharmacy	F 867	Added recitations to current Quality Assurance and Performance Improvement (QAPI) program for review. Reviewed QAPI program and adjustments were made as necessary. The Administrator has been reeducated by the Regional Vice President of	

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F 867	Continued From page 30 Services (F761) that were subsequently recited on the current recertification and complaint investigation survey of 05/02/24. The repeat deficiencies during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F636: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAAs) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 5 sampled residents (Residents #67 and #52). During the recertification and complaint survey of 06/04/21 the facility failed to complete the Minimum Data Set (MDS) within 14 days of a resident's admission for 1 of 5 sampled residents. F761: Based on observations, record review, and staff interviews, the facility failed to ensure a controlled substance medication ordered for a resident was safely stored and secured using a double lock feature for 1 of 4 medication storage refrigerators observed (Resident #65). A controlled substance has an accepted medical use, a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The facility also failed to date an open vial of insulin on 1 of 2 medication carts reviewed (300/400 hall medication cart) and failed to date a vial of Tuberculin Serum (used to conduct tuberculosis screening) and failed discard the Tuberculin serum after 30 days in 2 of 4 medication rooms	F 867	Operations concerning the policy QAPI Program. On 5/20/24, Administrator educated QAPI team on their roles and responsibilities during monthly QAPI meetings. The meeting minutes will be reviewed by the Regional Vice President of Operations or Regional Director of Clinical Services each month for 3 months. Random audits of identified issues will be done by the Regional Director of Clinical Services during visits. All audits will be reported to the QAA Committee for three months or until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 867	Continued From page 31 reviewed 300/400 hall medication cart and 500/600 hall medication cart). During the recertification and complaint survey of 06/04/21 the facility failed to ensure a controlled substance medication ordered for a resident was safely stored and secured using a double locked feature for 1 of 2 medication storage refrigerators observed. A controlled substance has an accepted medical use, a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. The facility also failed to remove medications placed at bedside for 1 of 1 resident were reviewed for medications left at bedside. The Administrator was interviewed on 05/02/24 at 4:50 PM. He stated that the Quality Assurance (QA) committee met on a monthly basis and included the administrator, Director of Nursing, Social Worker, Business office Manager, Unit Managers, MDS Coordinator's, Maintenance Director, and Medical Director. Each member of the QA committee had a role, and they were required to bring last month's data to review which included infections, falls, weights, wound, quality measures, risk tools, abuse investigations, medication errors, elopements, and any other issues that needed to be reviewed and discussed. The Administrator stated that the committee also reviewed all policy updates and conducted mock surveys to help achieve and maintain ongoing compliance. The Administrator stated that at least quarterly the QA committee reviewed previous survey data to ensure nothing had changed and through that review they identify areas of opportunity to put a plan of correction in place, do a grievance or any other action that the facility may need to improve upon.	F 867		

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