STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(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 survey was conducted on 5/10/21 through 5/13/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SIBN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/10/21 through 05/13/21. Event ID# S1BN11 4 of the 11 complaint allegation(s) was/were substantiated resulting in deficiencies.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		6/4/21

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

Electronically Signed | 06/04/2021

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F 561	Continued From page 1 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide a resident with their preferred number of showers a week for 1 of 1 sampled resident reviewed for choices (Resident #12). The findings included: Resident #12 was admitted to the facility on 3/7/19 with diagnoses that included right sided weakness due to brain injury and stroke. A Care Plan dated 3/19/19 indicated a self-care performance deficit related to hemiplegia. Goals included allow plenty of time of complete tasks and help as needed. Resident #12's Annual Minimum Data Set (MDS) dated 2/19/21 indicated he was cognitively intact. The MDS indicated he needed 1-person assistance with bathing, extensive assistance with dressing, toileting, and grooming. The MDS assessment indicated Resident #12 did not refuse evaluation or care. Review of facility shower schedule indicated Resident #12 was scheduled to get a shower on Wednesday and Saturday on evening shift (between 3 PM- 11 PM). Review of Resident #12's Daily Care Task list from 4/13/21 to 5/13/21 indicated the following: Wednesday, 4/14/21: shower on evening shift	F 561	F 561 Corrective Action For Self - Determination Resident #12 was asked to fill out a Resident Choice Questionnaire on Bathing and Showers on 6/2/21. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. Facility Managers provided all alert and oriented residents; along with the responsible parties of the cognitively impaired, a Resident Choice Questionnaire for containing the resident's preferences on 6/3/21. A resident preferred shower schedule was entered into PCC Tasks to alert the CNAs of the residents' desires and choice by the MDS Nurse on 6/3/21. All residents that preferred a bed bath over a shower, care plan was update on 6/3/21. Systemic Changes On 6/2/21, the Director of Nursing began in-servicing all current employees. This in-service included the following topics: • Residents Rights Choices (i.e., showers. baths, food, activities, ADL care, medication regimen, voting) The Director of Nursing will ensure that any staff who had not received this	

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F 561	Continued From page 2 Saturday, 4/17/21: bed bath on evening shift Wednesday, 4/21/21: shower on evening shift Saturday, 4/24/21: no documentation on evening shift Wednesday, 4/28/21: no documentation on evening shift Saturday, 5/1/21: bed bath on evening shift Wednesday, 5/5/21: shower on evening shift Saturday, 5/8/21: bed bath on evening shift During an interview 5/10/21 at 3:00 PM, Resident #12 stated he had not been getting showers twice a week as scheduled. He stated he did not get a shower Saturday 5/8/21 and no one offered a shower. This had been an on ongoing issue for months. He stated he received bed baths daily but showers only once per week, although he wanted showers twice a week. At initial visit, Resident #12 appeared clean and well groomed, dressed in street clothes, and was up to wheelchair in room. At a follow up observation on 5/12/21 at 9:30 AM, Resident #12 appeared groomed and dressed up to wheelchair. He reported staff got him up that morning and assisted with personal hygiene. During an interview 5/12/21 at 11:15 AM, the MDS nurse stated that Nurse Aides (NA) were responsible for giving showers. She further stated shower preference were not in the Care Plan, but staff knew the Resident #12's preference because he had been there so long. During an interview on 5/12/21 at 3:10 pm, Nurse Aide (NA) #1 indicated that she assisted Resident #12 with showers on Wednesdays. She stated he usually is ready for his shower when she gets there. She further stated he has not declined a shower nor requested a different time since she	F 561	training by 6/4/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring: • Residents right to choose bath, v/s, shower, days desire, and an option on time. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of life/Quality Assurance as appropriate. The Quality of Life Committee consist of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager, and Social Worker. Date of compliance 6/4/21	

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F 561	Continued From page 3	F 561		

has worked with him. NA #1 stated she does not work usually work weekends and does not know if Resident #12 received Saturday showers. She stated if NAs cannot get the scheduled tasks completed, it should be communicated to the charge nurse.

During an interview 5/14/21 at 10:30 AM, Nurse #1 reported he worked the weekend of 5/8/21. He did not recall the NA reporting issues providing showers 5/8/21. He further stated residents should get shower regardless of short staffing. He reported Resident #12 did get a shower on 5/13/21 (Thursday) by evening shift.

During an interview 5/14/21 at 2:30 PM, NA #3 recalled being assigned to Resident #12 5/8/21 until 9 PM. She stated she did not recall seeing Resident #12 on the shower schedule list and she did not give him a shower. Prior to leaving the facility, she gave report the other NAs on duty and the charge nurse.

NA #4 was assigned to Resident #12 on 4/24/21 and 5/1/21 evening shift and could not be reached for interview at multiple attempts.

During an interview on 5/14/21 at 2:45 PM, the Director of Nursing (DON) stated nursing staff should be offering showers as scheduled and documenting refusal. If residents wanted to change shower days or times, staff would work with residents to accommodate. She further stated shower preferences should be communicated through the Care Plan. The DON further indicated staff felt comfortable bringing workload concerns to her, but she had not heard any concerns about not being able to get work done. She further stated if she had heard

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F 561	Continued From page 4 concerns, she would have worked to find a resolution. She stated leadership nurses were available to assist with NA tasks and agency staff was always available. NAs should report to the charge Nurse if they cannot get their tasks completed. During an interview 5/14/21 at 3:40 PM, the Administrator stated residents should be getting showers according to preference.	F 561		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		6/4/21

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F 645	Continued From page 5	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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F 645	Continued From page 6 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to apply for a level II (Preadmission Screening and Resident Review) PASRR screening for 3 of 5 residents reviewed for PASRR II screenings (Resident# 52, Resident 35 and Resident 21). Findings included: 1.A review of the medical record revealed Resident # 52 was admitted to the facility on 04/22/2019 with diagnosis including, Depression and Psychotic disorder diagnosis added 11/26/2019. The Annual Minimum Data Set (MDS) dated 04/23/2021 noted Resident # 52 to be severely cognitively impaired and needed extensive assistance with bed mobility, transfer, dressing, eating, toileting and personal hygiene. The MDS coded the resident to have the following diagnoses: Depression and Psychotic disorder. MDS did not code Resident # 52 to have been evaluated for a PASRR level II. On 05/12/2021 at 10:10 AM, the Admission Coordinator who was a former Social Worker (SW) was interviewed. She stated she did not know the reason the PASRR level II screening for Resident # 52 was not completed. The Admission coordinator further indicated she could not find the letter indicating PASRR II screening was completed for Resident # 52. In an interview on 05/12/2021 at 1:30 PM, the Administrator expressed the PASARR level II	F 645	F645 PASSR Screening for MD and ID Corrective actions for Resident #52 Specific deficiency for Resident #52 was resolved on _5_/11/21 by the facility Social Services Director who submitted a new request for review via NCMUST. The facility is waiting for an update on the resident's PASSR. Corrective actions for Resident #35 Specific deficiency for Resident #35 was resolved on _5_/_11/21 by the facility Social Services Director who submitted a new request for review via NCMUST. The resident now has a Level II PASSR. Corrective actions for Resident #21 Specific deficiency for Resident #21 was resolved on _5_/_11/21 by the facility Social Services Director who submitted a new request for review via NCMUST. The facility is waiting on an update on the resident's PASSR. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents who have diagnosis of a serious mental illness or Intellectual/Developmental Disabilities was completed in order to validate that the resident(s) with these diagnosis have been reviewed by the State Mental Health Authority and that reviews are up to date. Any resident who is identified as not having had a Level II PASRR review by	

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F 645	Continued From page 7 information is expected to be completed immediately if a resident has psychiatric diagnoses and She also expressed all residents should be reviewed and screened for any needed Level II PASRR assessments when changes occur. 2. A review of the medical record revealed Resident # 35 was admitted to the facility on 03/22/2021 with diagnoses including Post Traumatic Stress disorder. The Admission Minimum Data Set (MDS) dated 03/26/2021 noted Resident # 35's cognition to be intact and he required extensive assistance with bed mobility and transfer. The MDS coded the resident to have a diagnosis of Posttraumatic Stress disorder. MDS did not code Resident # 35 to have been evaluated for a PASRR level II. On 05/12/2021 at 10:10 AM, the Admission Coordinator who was a former Social Worker (SW) was interviewed. She stated she did not know the reason the PASRR level II screening for Resident # 35 was not completed. The Admission coordinator further indicated she could not find the letter indicating PASRR II screening was completed for Resident # 35. In an interview on 05/12/2021 at 1:30 PM, the Administrator expressed the PASARR level II information is expected to be completed immediately if a resident has psychiatric diagnoses and She also expressed all residents should be reviewed and screened for any needed Level II PASRR assessments when changes occur.	F 645	the State Mental Health Authority via NCMUST will have this completed immediately by the facility Social Services Director. This audit was completed by Jalia Anderson Social Worker and Ashley Forte Admissions Coordinator 05/13/21. Audit results are: 37 of 73 residents reviewed were noted to have a diagnosis of severe mental illness or intellectual disability/ developmental disabilities. __33_ of _73 residents who have diagnosis of severe mental illness or intellectual disability/developmental disabilities DID have evidence of having an up to date Level II PASRR screening completed. __20_ of 73___ residents who have diagnosis of severe mental illness or intellectual disability/developmental disabilities DID NOT have evidence of having completion of an up to date Level II PASRR screening. All residents who were identified as having a diagnoses of severe mental illness or intellectual disability/developmental disabilities and DID NOT have evidence of having been referred to state mental health authority for new PASARR screening via NCMUST had a new request for PASRR level review sent via NCMUST. This was completed by the facility Social Services Director on ¬¬6/3/21.	

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F 645	Continued From page 8 3. A review of the medical record revealed Resident # 21 was admitted to the facility on 05/29/2020 with diagnoses including Depression, Psychotic. The Admission Minimum Data Set (MDS) dated 06/05/2020 noted Resident # 21's cognition to be moderately impaired, he required extensive assistance with bed mobility and dressing. The resident was coded for the following diagnoses: Depression and psychotic disorder. MDS did not code Resident # 21 to have been evaluated for a PASRR level II. On 05/12/2021 at 10:10 AM, the Admission Coordinator who was a former Social Worker (SW) was interviewed. She stated she did not know the reason the PASRR level II screening for Resident # 21 was not completed. The Admission coordinator further indicated she could not find the letter indicating PASRR II screening was completed for Resident # 21. In an interview on 05/12/2021 at 1:30 PM, the Administrator expressed the PASARR level II information is expected to be completed immediately if a resident has psychiatric diagnoses and She also expressed all residents should be reviewed and screened for any needed Level II PASRR assessments when changes occur.	F 645	Systemic Changes All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Developmental Disabilities have the potential to be impacted. On 06/03/21, the Regional Minimum Data Set Education and Compliance Consultant completed an in-service training for the facility Social Services Director and Minimum Data Set Coordinator that included the importance of thoroughly reviewing each resident's medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/developmental disabilities. It is very important that the medical record is thoroughly reviewed upon resident admission to facility, as well as afterwards in order to promptly identify the addition of mental illness and/or intellectual disability diagnoses. The education also included the importance of ensuring that upon admission, a request for a Level II PASRR screening be submitted to the state mental health authority via NCMUST. In addition to newly admitted residents, a request for a new screening must be submitted via NCMUST for Level II residents according to the time limit based on their prior Level II review as well as anytime they experience a significant change in condition. This information has been integrated into	

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the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Director of Nursing or designated Nurse Manager will begin auditing residents who have a diagnoses of a severe mental illness and/or intellectual disabilities/developmental disabilities to ensure that state mental health authority is notified via NCMUST system upon admission to the facility and as required according to each resident's time limited PASRR, using the quality assurance survey tool entitled "PASRR Screening Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements.
This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director.

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F 645	Continued From page 10	F 645	The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 06/04/21	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		6/4/21

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F 725	Continued From page 11 Based on observations, record review, resident and staff interviews, the facility failed to provide nursing staff of sufficient quantity resulting in bed baths given when showers were preferred. This affected 1 of 1 resident (Resident #12) reviewed for choices. The findings included: This tag is cross referred to: F561: Based on observations, record review, resident and staff interviews, the facility failed to provide a resident with their preferred number of showers a week for 1 of 1 sampled resident reviewed for choices (Resident #12). During an interview on 5/13/21 at 11:30 AM, NA #2 stated some weekends they were short staffed, and two NAs were required to care for 15-20 residents. She stated it was difficult for two NA to provide showers for the residents scheduled and would substitute a bed bath. She further stated the residents communicated their preferences, but it was hard to accommodate due to being short staffed. She stated it was ok to substitute a bed bath for a shower. During an interview 5/14/21 at 9:30 AM, the nursing staff scheduler reported the facility has part time NAs, nurses, and agency staff to provide care when they were short staffed or when staff calls out. She stated she was a NA and can assist in providing care when staffing was short. During an interview 5/14/21 at 2:30 PM, NA #3 recalled working at the facility briefly though a nursing staffing agency. She reported staffing on the weekends often short staffed due to call outs	F 725	F 725 Corrective Action for Sufficient Nursing Staff Resident # 12 was asked to fill out a Resident Choice Questionnaire on Bathing and Showers on 6/2/21. Resident's choice was added to new facility shower schedule on 6/2/21. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. Facility Managers provided all alert & oriented residents; along with the responsible parties of the cognitively impaired, a Resident Choice Questionnaire for Bathing and Showers on 6/2/2021. The Director of Nursing compiled all choices and created a new shower schedule, containing the resident's preferences on 6/3/21. A resident preferred shower schedule was entered into PCC Tasks to alert the CNAs of the residents' desires and choice by the MDS Nurse on 6/3/21. All residents that preferred a bed bath over a shower, care plan was update on 6/3/21. Systemic Changes On 6/2/21, the Director of Nursing began in-servicing all current employees. This in-service included the following topics:	

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F 725	Continued From page 12 and often care went undone due to this. She recalled showers not completed due to being short staffed. During an interview on 5/14/21 at 2:45 PM, the Director of Nursing (DON) reported staffing is based on resident acuity and census numbers. She stated staff would bring workload concerns to her, but she had not heard any concerns about not being able to get work done. She further stated if she had heard concerns, she would have worked to find a resolution. She stated leadership nurses were available to assist with NA tasks and agency staff was always available. During an interview 5/14/21 at 3:40 PM, the Administrator reported that staffing agency staff is always available if nursing staff may be short. The expectation is that residents have needs met according to preference and showers were given as scheduled.	F 725	- Residents Rights Choices (i.e. showers, baths, food, activities, ADL care, medication regimen, voting) - Additional staff has been scheduled during high volume shower/bath times to accommodate residents' preferences. - A dedicated shower coordinator has been assigned to oversee the shower schedule and that residents choices are being met. Quality Assurance The Director of Nursing will ensure that any staff who had not received this training by 6/4/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring: - Residents' right to choose bath v/s shower, days desire, and an option on time. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life – QA committee and corrective action initiated as appropriate. The Quality of Life Committee consist of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, unit support Nurse, MDS Coordinator, Business Office	

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F 725	Continued From page 13	F 725	Manager, Health Information Manager, Dietary Manager, and social worker. Date of compliance: 6/4/21	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications in 2 of 2 medication storage rooms (the 300/400 Hall Med Room and the 500 Hall Med Room); and	F 761	F 761 Corrective Action for Medication Storage Pyxsis drawer (medication dispense	6/4/21

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F 761	Continued From page 14 failed to store medications in accordance with the manufacturer's storage instructions in 1 of 3 medication carts observed (200 Hall med cart). The findings included: 1. Accompanied by Nurse #1, an observation was made on 5/10/21 at 3:30 PM of the 300/400 Hall Med Room. The observation revealed six (6) intravenous (IV) solution bags containing vancomycin (an antibiotic) dispensed for Resident #37 were stored in the med room refrigerator. The bags were labeled with a pharmacy expiration date of 5/9/21. Upon review of the labeling on the IV bags, Nurse #1 confirmed the intravenous solution bags were expired and he was observed to remove them from the med room refrigerator. A follow-up interview was conducted on 5/11/21 at 4:15 PM with Nurse #1. During this interview, the nurse reported he gave the intravenous solution bags containing vancomycin to the Director of Nursing (DON) so they could be sent back to the pharmacy. In the presence of Registered Nurse (RN) Supervisor #1, an interview was conducted with the facility ' s DON on 5/12/21 at 9:00 AM. During the interview, the DON acknowledged the IV solution bags of vancomycin were expired when found and reported she was in the process of sending them back to the pharmacy. The DON stated this medication had been discontinued for the resident but did not get sent back to the pharmacy as it should have been. The DON reported she would have expected the IV solution bags to have been brought to her so they could have been sent back as quickly as possible. 2. Accompanied by Nurse #2, an observation	F 761	machine) was repaired by Pharmacy Tech on 4/20/21 All expired medication identified were removed by the Unit Manager on 4/21/21 and disposed of Medication Dispense cart secured. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 5/21/21, the Nurse Manager audited all med carts for expired and the medication storage room to ensure no expired medications were present. This was completed on 5/21/21. Systemic Changes On 5/21/21 the Staff Development Coordinator began in-servicing all current licensed nurses. This in-service included the following topics: • Director of Nursing or designated Nurse Manager will audit the Med Dispense system weekly x4 weeks then monthly x2 for any expired medications. • Pharmacy/Director of Nursing will be notified immediately for any dysfunction of the Med Dispense System for repair The Director of Nursing will ensure that any licensed nurses or Agency nurses who has not received this training by 5/24/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance	

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F 761	Continued From page 15 was made on 5/10/21 at 3:45 PM of the 500 Hall Med Room. The observation revealed three (3) - 15 milliliter (ml) stock bottles of Systane lubricant eye drops (an over-the-counter eye drop indicated for the treatment of dry or irritated eyes) with a manufacturer expiration date of April 2021 were stored in the med room. An interview was conducted with Nurse #2 on 5/10/21 at 3:50 PM. During the interview, the nurse confirmed the Systane eye drops were expired and needed to be sent back to the pharmacy. In the presence of Registered Nurse (RN) Supervisor #1, an interview was conducted with the facility ' s Director of Nursing (DON) on 5/12/21 at 9:00 AM. During the interview, the DON reported she had not been made aware of the expired eye drops stored with the stock medications in the 500 Hall Med Room. When asked, the DON stated she would have expected any expired prescription or over-the-counter (OTC) medications to be brought to her for discarding or return to the pharmacy. 3. Accompanied by Med Aide #1, an observation was made on 5/11/21 at 11:00 AM of the 200 Hall medication cart. The observation revealed two - 80 micrograms (mcg) / 4.5 mcg budesonide / formoterol aerosol inhalers labeled for Resident #17 were stored lying down on their side in the top drawer of the medication cart. One inhaler was labeled as dispensed from the pharmacy on 4/15/21; the second inhaler ' s label indicated it was dispensed from the pharmacy on 5/10/21. A bright orange pharmacy auxiliary sticker adhered to each plastic canister of the aerosol inhalers read in part: " ...Store with mouthpiece down..."	F 761	The Director of Nursing will monitor this issue using the Survey Quality Assurance4 Tool for Monitoring for expired medications. The monitoring will include reviewing. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance 5/28/21	

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Budesonide / formoterol is a combination medication containing an inhaled corticosteroid used for the treatment of asthma and/or chronic obstructive pulmonary disease.

An interview was conducted on 5/11/21 at 11:10 AM with Med Aide #1. During the interview, the medication aide reviewed the pharmacy auxiliary sticker placed on the budesonide/formoterol inhalers. Med Aide #1 stated she had not previously noticed the instructions which indicated the inhalers needed to be stored with the mouth piece down.

A review of Resident #17's physician's orders revealed there was a current order for 80 mcg - 4.5 mcg budesonide / formoterol aerosol inhaler to be administered as two puffs inhaled orally two times a day for the treatment of asthma.

In the presence of Registered Nurse (RN) Supervisor #1, an interview was conducted with the facility ' s Director of Nursing (DON) on 5/12/21 at 9:00 AM. During the interview, the DON discussed her expectations for the proper storage of medications. The DON reported she would expect nursing staff to store inhalers with the mouth piece down when indicated by the manufacturer and/or pharmacy instructions. She stated, "I think this is an education issue."

4. Accompanied by Med Aide #1, an observation was made on 5/11/21 at 11:00 AM of the 200 Hall medication cart. The observation revealed a 160 micrograms (mcg) / 4.5 mcg budesonide / formoterol aerosol inhaler dispensed from the pharmacy on 4/25/21 and labeled for Resident #49 was stored lying down on its side in the top drawer of the medication cart. A bright orange

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pharmacy auxiliary sticker adhered to the plastic canister of the aerosol inhaler read in part: " ...Store with mouthpiece down..." Budesonide / formoterol is a combination medication containing an inhaled corticosteroid used for the treatment of asthma and/or chronic obstructive pulmonary disease.

An interview was conducted on 5/11/21 at 11:10 AM with Med Aide #1. During the interview, the medication aide reviewed the pharmacy auxiliary sticker placed on the budesonide / formoterol inhaler. Med Aide #1 stated she had not previously noticed the storage instructions which indicated the inhaler needed to be stored with the mouth piece down.

A review of Resident #49's physician's orders revealed there was a current order for 160 mcg - 4.5 mcg budesonide / formoterol aerosol inhaler to be administered as two puffs inhaled orally two times a day for respiratory health.

In the presence of Registered Nurse (RN) Supervisor #1, an interview was conducted with the facility ' s Director of Nursing (DON) on 5/12/21 at 9:00 AM. During the interview, the DON discussed her expectations for the proper storage of medications. The DON reported she would expect nursing staff to store inhalers with the mouth piece down when indicated by the manufacturer and/or pharmacy instructions. She stated, "I think this is an education issue."

5. Accompanied by Med Aide #1, an observation was made on 5/11/21 at 11:00 AM of the 200 Hall medication cart. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) was

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stored lying down on its side in the top drawer of the medication cart. The manufacturer ' s storage instructions printed on the label of the box containing the eye drops read in capital letters, "Store Upright."

An interview was conducted on 5/11/21 at 11:10 AM with Med Aide #1. During the interview, the medication aide was shown the manufacturer ' s storage instructions printed on the label of the eye drop medication. Med Aide #1 reported she was not aware the medication needed to be stored in an upright position.

In the presence of Registered Nurse (RN) Supervisor #1, an interview was conducted with the facility ' s Director of Nursing (DON) on 5/12/21 at 9:00 AM. During the interview, the DON discussed her expectations for the proper storage of medications included making sure nursing staff were educated to ensure ophthalmic suspensions were stored upright. She stated, "I think this is an education issue."