STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGECOMBE HEALTH AND REHAB CENTER	1000 WESTERN BOULEVARD TARBORO, NC 27886

(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 11-29-21 through 12-2-21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CQ0W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11-29-21 through 12-2-21. Event ID# CQ0W11 One of the 3 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		1/5/22

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

Electronically Signed | 12/22/2021

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interview, the facility failed to (1) notify the physician of a resident (Resident #50), reviewed for notification who was exhibiting mental health symptoms such as depression, speaking to someone who was not there and believing there were cameras in his television watching him and the facility failed to (2) notify a resident (Resident #85) of a change in psychotropic medication. This occurred for 2 of 2 residents reviewed for notification of change.	F 580	1. Resident # 50 was seen by psychiatric nurse practitioner on 12/6/21. There were no medication changes as resident denied any current issues with hallucinatory behaviors or delusions. Resident interview by psych revealed resident was sleeping well. Psychiatric services will continue with resident and adjustments to his plan of care will be made if indicated. The attending physician visited with the resident on 12/20/21 with no noted	

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F 580	Continued From page 2 Findings included: 1. Resident #50 was admitted to the facility on 9-15-21 with multiple diagnoses that included fracture of the scapula (left shoulder) and fracture of right lower leg. The modified admission Minimum Data Set (MDS) dated 9-22-21 revealed Resident #50 was minimally cognitively impaired and was coded as feeling depressed, down or hopeless for 2-6 days. During an interview with Nursing Assistant (NA) #2 on 12-1-21 at 2:25pm, NA #2 stated Resident #50 often hallucinated by speaking to someone or something that was not there and had discussed with her that he believed there were cameras in his television and staff were watching him. She stated she could not document the resident's behavior in the computer, but she reported the symptoms to the nurse (Nurse #2). On 12-2-21, Nurse #2 was interviewed at 9:00am. Nurse #2 stated she had seen the resident depressed, staring at the floor and never smiling. The nurse stated she had not notified the physician because she thought it was normal for the resident to be depressed after his accident and that he would adjust to his change in condition. The facility Physician was interviewed by telephone on 12-1-21 at 3:15pm. The Physician discussed Resident #50 being admitted to the facility on Seroquel (antipsychotic medication) from the hospital which was prescribed at bedtime for behaviors. He explained there was	F 580	behaviors and no changes in medicine. The responsible party was given an update on 12/20/21 regarding the psychiatric visit and the visit by the Medical Doctor on 12/20/21. Resident #85 had a medication variance report completed on 12/20/21 by the Assistant Director of Nursing regarding the Sertraline being discontinued. On 12/16/21 the Sertraline was started back. Resident was seen by psych on 12/20/21 with no new orders and review medication change with resident. Resident was also informed of medication change by Social Worker on 12/20/21. 2. All residents that experience changes in their mental health symptoms are at risk and warrant notification to the Medical Doctor. All residents that have psychotropic medication changes are at risk for not being notified of the change in medication regimen. 3. A PHQ 9 and mental health assessment will be completed on all residents by a social service or licensed nurse by 1/5/22. The Medical Doctor will be notified of any significant changes identified with psychiatric consultation if indicated. Pharmacy consultant recommendations for the month of November were reviewed and the residents and Responsible parties were informed of any changes in the plan of care related to psychotropic medication changes. This was completed by the Assistant Director of Nursing by 1/5/22.	

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F 580	Continued From page 3	F 580		

little information about Resident #50's mental health and he had discontinued the Seroquel upon admission. The Physician affirmed he had not been made aware of Resident #50's depression or ideations of a camera in his television and stated discontinuing the Seroquel could have unmasked an underlining mental illness.

The Director of Nursing (DON) was interviewed on 12-2-21 at 10:53am. The DON stated she was not aware of any mental health symptoms with Resident #50. She explained the nursing assistants can document resident behaviors in the computer which would trigger Social Work to further investigate, and the Social Worker would have contacted the physician.
2. Resident #85 was admitted to the facility on 10/17/19 with diagnoses that included depression.

A pharmacy consultant recommendation dated 8/18/21 indicated a Gradual Dose Reduction (GDR) of Resident #85's physician's order for Sertraline HCl (antidepressant) 75 milligrams (mg) to 50 mg was recommended. The physician indicated he agreed with the recommendation on 8/31/21.

Review of physician orders revealed Resident #85's 75 mg Sertraline (initiated on 8/5/20) was discontinued on 9/28/21 by the physician's assistant and entered by Nurse #6.

Resident #85's Minimum Data Set (MDS) assessment dated 10/21/21, an annual assessment, revealed she was cognitively intact and was coded as feeling down or depressed and having little interest in doing things 7-11 of the last

4. Current licensed nurses will be educated regarding notification to the Medical Doctor when they are alerted or identify changes in a resident□s mental health symptoms. This education will include completion of an SBAR progress note. This education will be provided by the Director of clinical education or Assistant Director of Nursing and will be completed by 1/5/22 and will be added to orientation for new hires.

Current licensed nurses will be educated regarding notifying a resident when they have a change in a psychotropic medication. This education will be provided by the Director of clinical education or Assistant Director of Nursing and will be completed by 1/5/22 and added to orientation for new hires.

5. As part of clinical daily startup, the SBAR progress notes will be reviewed with validation that the Medical Doctor and responsible party have been notified of changes in residents mental health status. As part of clinical startup daily, review of all psychotropic medication changes will be reviewed for evidence that the resident and responsible party have been informed of the medication changes.

This education will be provided by the Director of Clinical education or Assistant Director of Nursing and will be completed by 1/5/22 and added to orientation for new hires.

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F 580	Continued From page 4 14 days. The resident was administered no antidepressant medication during the MDS review period. During an interview with Resident #85 on 12/2/21 at 12:19 PM she stated she was never informed that her Sertraline was discontinued. She reported she wanted her antidepressant restarted as it was helpful in treating her depression. An interview was attempted with Nurse #6 on 12/2/21 at 12:14PM and she was unable to be reached. During an interview with the Director of Nursing (DON) on 12/2/21 at 12:23 PM she stated residents should be notified when their medications were changed or discontinued. The DON indicated the provider should have notified the resident of the change in medications. An interview was conducted with the Medical Director on 12/1/21 at 3:13 PM who stated the pharmacy consultant recommended a GDR of Sertraline and he agreed with this recommendation as he usually followed the consultant pharmacist's recommendation. He stated he did not recall receiving a request to discontinue Resident #85's antidepressant medication on 9/28/21. The Medical Director indicated he was not involved in notifying residents of medication changes recommended by the consultant pharmacist.	F 580	A monitoring tool will be used to record the results of the Daily Clinical Startup audits of Notification of changes in mental health status and Notification of changes in psychotropic medication these monitoring tools will be completed weekly and presented monthly x 3 months (Jan, Feb, March 2022)at QAPI meeting. This plan of correction will be completed by 1/5/22.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		1/5/22

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F 641	Continued From page 5 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review the facility failed to accurately code the Preadmission Screening and Resident Review (PASARR) status on a Minimum Data Assessment (MDS) for 1 of 1 resident reviewed for PASARR (Resident #70) and failed to accurately code the hospice status of a resident on an MDS assessment for 1 of 2 residents reviewed for hospice (Resident #3). Findings included: 1. Resident #70 was admitted to the facility on 11/19/18. Her active diagnoses included anxiety disorder, unspecified persistent mood [affective] disorder, and major depressive disorder. Resident #70's PASARR level II determination notification dated 11/12/20 revealed she was assessed to be level II PASARR. Resident #70's Minimum Data Set assessment dated 10/12/21 revealed she was assessed to not have a level II PASARR. During an interview on 12/01/21 at 9:47 AM MDS Nurse #1 stated Resident #70 was a PASARR level II and the MDS dated 10/12/21 was incorrect, and she would start a modification of the MDS. During an interview on 12/01/21 at 10:04 AM the Administrator stated PASARR status was to be accurately coded on Minimum Data Set assessments. 2. Resident #3 was admitted to the facility on 3/23/21 with diagnoses that included dementia	F 641	1. Resident #70 (MINIMUM DATA SET) MDS with an ARD of 10/21/21 was modified by the MDS coordinator on 12/1/21 to reflect PASARR level 2. Resident #3 MDS with an ARD of 11/16/21 was modified by the MDS coordinator on 12/2/21 to reflect hospice. 2. All residents that are level 2 and hospice are at risk for MDS coding issues. 3. Current Level 2 PASARR and hospice residents MDS□s completed since 7/1/21 were audited by the MDS Coordinator and modifications were completed if necessary. 4. The District Director of care management provided education to the MDS coordinators, Administrator and Director of Nursing regarding the MDS coding requirements related to Level 2 PASARR and Hospice residents using the RAI manual as a guide. This education was completed on 12/2/21. 5. The MDS Nurses will maintain a list of all PASARR level 2 and Hospice residents and prior to transmission of the MDS, will audit that they have correct coding. A monitoring log will be used to validate this audit prior to transmission of the MDS. This will be maintained for 3 months and the findings will be presented at QAPI monthly for three months with adjustment in the plan if indicated.	

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F 641	Continued From page 6 and diabetes mellitus. Review of physician's orders revealed an order to admit Resident #3 for hospice dated 9/15/21. Resident #3's quarterly Minimum Data Set (MDS) assessment dated 11/6/21 revealed no hospice services were received while in the facility. During an interview with the MDS nurse on 12/2/21 at 10:04 AM who stated Resident #21's assessment should have been coded to reflect his hospice status and the error was an oversight. An interview was conducted with the Administrator on 12/2/21 at 12:05 PM who stated Resident #3's MDS assessment dated 11/6/21 should have been coded accurately to reflect services received.	F 641	This corrective action will be completed by 1/5/22.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		1/5/22

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F 656	Continued From page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan to address a significant diagnosis for 1 of 5 resident (Resident #104) reviewed for care plans. Findings included: Resident #104 was admitted to the facility on 8/26/2021 with diagnoses that included peripheral vascular disease and atherosclerotic heart disease (a buildup of plaque inside of the artery walls).	F 656	1. Resident #104 expired October 4, 2012 therefor the plan of care cannot be corrected. 2. All residents that are on anticoagulant therapy are at risk for the plan of care not reflecting the diagnosis related to the use of anticoagulant therapy. 3. An order listing report for all residents on anticoagulant therapy was used to audit all careplans and to ensure the	

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F 656	Continued From page 8 Review of an admission Minimum Data Set (MDS) dated 9/2/2021 indicated Resident #104 was cognitively intact. It was coded that Resident #104 was not on an anticoagulant. A nursing note dated 9/7/2021 written by Nurse #3 revealed Resident #104 had a doppler study (a test that measures the amount of blood that flows through the arteries and veins) and the results were positive for deep vein thrombosis (DVT) (a blood clot that forms in one or more of the veins). The note indicated the physician was informed. The physician order dated 9/7/2021 revealed Apixaban (blood thinner) 10 milligram (mg) by mouth twice a day for 7 days, then 5 mg twice a day for DVT. Avoid physical therapy to left lower extremity (LLE) for 3 days and keep LLE elevated. A review of the comprehensive care plan dated 9/17/2021 revealed no plan to address Resident #104's DVT. A care plan initiated on 9/21/201 addressed anticoagulant therapy related to atherosclerotic heart disease. There was no intervention to elevate the LLE in the plan of care. An interview with Nurse Aide (NA) #1 on 12/1/2021 at 11:00 am revealed she remembered when Resident #104 was diagnosed with DVT. She stated she went into Resident #104's room and asked if she was ready to get out of the bed. She then stated Resident #104 told her she must not have read her chart because she had to keep her left leg elevated. NA #1 stated she had not been informed of Resident #104's diagnosis	F 656	correct diagnosis is reflected on the plan of care. This audit will be completed by the MDS Consultant on 1/5/22. 4. The District Director of Clinical services provided an inservice to the MDS nurses, Unit Managers, Assistant Director of Nurse, Staff Development Nurse, and the Director of Nursing on 12/2/21 regarding careplan practices as it relates to anticoagulant therapy to include the correct diagnosis and interventions relevant to the diagnosis. This was completed on 12/2/21. 5. As part of clinical startup 5 x weekly, any resident with order changes related to anticoagulant therapy careplan□s will be reviewed and updated as indicated. A monitoring tool will be used during clinical startup to reflect this. The monitoring tool will be maintained for three months and the results will be reported to QAPI monthly x 3 months with adjustments to the plan if indicated.	

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F 656	Continued From page 9 before she entered the room. During an interview with MDS Nurse #2 on 12/1/2021 at 9:40 am she stated the facility had daily meetings to discuss changes in the resident's condition. She stated she did not recall hearing about Resident #104's DVT diagnosis. MDS Nurse #2 then stated the DVT diagnosis should have been captured on the care plan. She further stated since Resident #104 was on an anticoagulant (Apixaban) she missed the DVT diagnosis because she thought the anticoagulant was for atherosclerotic heart disease. On 12/2/2021 at 10:00 am the Director of Nursing stated during an interview it was more important to her that the DVT diagnosis was captured on the daily report than on the care plan. She then stated it was clearly on the care plan that she was taking an anticoagulant. The DON confirmed the DVT diagnosis was not addressed on the care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		1/5/22

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F 657	Continued From page 10 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to invite a moderately cognitively impaired resident to a care plan meeting (Resident #78) and failed to revise a care plan (Resident #69) for 2 of 5 residents reviewed for care plans. Findings included: 1. Resident #78 was admitted to the facility on 6/14/21. Her active diagnoses included stroke, anemia, and hypertension. A review of her quarterly Minimum Data Set assessment dated 10/14/21 revealed on her Brief Interview for Mental Status (BIMS) assessment she was documented as scoring a 12. (BIMS score interpretations: 0 - 7 indicates severe cognitive impact, 8 - 12 indicates Moderate impairment, and 13 - 15 indicates Intact cognitive response) She had no behaviors. Review of a progress note dated 10/20/21	F 657	1. Resident #78 plan of care was reviewed with her on 12/20/21 by Social Worker. Resident # 69 was updated on 12/20/21 by MDS Coordinator to accurately reflect resident catheter care versus incontinence. 2. All residents that are able to understand the careplan reviews are at risk for the careplan not being reviewed. All residents with catheters are at risk for careplan not accurately reflecting the catheter/continence/incontinence status. 3. An audit will be conducted of current residents to determine if their plan of care had been reviewed with them. Residents that did not have severely impaired cognition had a review completed with them regarding plan of care if it was determined it had not been done. This	

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F 657	Continued From page 11 revealed a care plan meeting was held by phone with the Responsible Party. Medications, weight, and by mouth intake were reviewed with the Responsible Party. Advanced directives, and contact list all up to date. The Responsible Party had questions about therapy, and the rehab manager was able to answer all her questions. Resident #78 was currently not on therapy. The Responsible Party did express she would like Resident #78 up, and out of the bed at least once a week. The wing manager would be notified of this request. The Responsible Party was very complimentary about the staff, and expressed how thankful she was, and that "the staff was doing a great job with her mom." The social worker would continue to follow up with Resident #78. A review of the chart revealed no indication Resident #78 had been notified of or invited to the care plan meeting. During an interview on 11/29/21 at 10:48 AM Resident #78 stated she did not get invited to care plan meetings but if she could ask questions about her care, she would like to attend. During an interview on 11/30/21 01:40 PM the Social Worker stated the last care plan meeting they had for Resident #78 was on 10/20/21. Resident #78 did not attend. She stated Resident #78 was not offered to be at the care plan meeting. Resident #78's daughter and son attended, and the daughter told her it was okay to just speak with her. The Social Worker indicated residents who were able to attend care plan meetings should be invited. She concluded Resident #78 should have been invited and she must have just sent the letter to the family and not	F 657	audit and careplan review will be completed by Social Worker by 1/5/22. An audit of current resident plan of care related to their continence /incontinence/catheter status will be completed by MDS Coordinator by 1/5/22. Any changes necessary to the plan of care was made by the MDS Coordinator. 4. The District Director of clinical provided the Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social services Director, the Staff education coordinator, and the MDS (Minimum Data Set) Coordinators, Dietary Manager and the Activity Department regarding the careplan timing and revision regulation on 12/1/21. 5. An audit tool was created to record each resident that has a scheduled careplan review and to reflect who reviewed the plan of care with the resident if they were not severely cognitively impaired. This audit tool will also reflect the validation that the catheter/continence and incontinence status reflect the resident continence/incontinence /catheter status. This audit tool will be completed weekly x 12 weeks. The audit tool will be reviewed at QAPI monthly for three months.	

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	345195	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 657	Continued From page 12	F 657		

remembered to notify the resident.

During an interview on 11/30/21 at 1:51 PM the Administer stated residents who were able and wanted to attend their care plan meetings should be invited their care plan meetings. She concluded Resident #78 should have been invited to her care plan meeting on 10/20/21.

2. Resident #69 was admitted to the facility on 11/11/2020 with diagnoses that included neurogenic bladder and chronic kidney disease.

A review of the current care plan revealed a plan that addressed bladder incontinence. The plan was last reviewed 10/18/2021. The intervention included clean peri-area after each incontinence episode.

A review of the physician orders dated 8/11/2021 insert ureteral foley catheter 18 french with a 10 milliliter balloon and a closed drainage system due to neurogenic bladder.

The current Minimum Data Set dated 11/9/2021 indicated Resident #69 was moderately cognitively impaired. The MDS was coded for an indwelling catheter and urinary continence was not rated.

An observation and interview on 11/29/2021 at 11:00 am with Resident #69 revealed she was resting in bed with her eyes open. A catheter drainage bag was observed hanging on the side of her bed. She state that her indwelling catheter had messed up earlier and the nurse had repositioned it. She pointed to where a catheter stabilizer was on her leg and pulled the covers back to expose the stabilizer and indwelling catheter tubing.

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F 657	Continued From page 13 During an interview with MDS #2 on 12/1/2021 at 9:40 am she stated Resident #69 currently had an indwelling catheter. She stated she left bladder incontinence on the plan of care because sometimes the catheter would come out and the physician may leave it out for a few days. She then stated she thought if it stayed on the plan of care when the catheter came out again, it would already be captured on the plan of care. She further stated the plan of care should have been revised to remove bladder incontinence. During an interview with the Director of Nursing (DON) on 12/1/2021 at 10:00 am the DON stated if Resident #69 did not have the catheter, she would be incontinent. She then stated the indwelling catheter had to be on the plan of care also. She stated MDS Nurse #2 explained to her why she left it on the plan of care. The DON then stated the plan of care should have accurately reflected Resident #69's urinary status.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to obtain daily	F 684	1. The Director of Nursing informed the attending Physician about resident # 354	1/5/22

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F 684	Continued From page 14 weights as ordered by the physician for a resident with a pleural effusion (Resident #354). This occurred for 1 of 1 resident (Resident #354) reviewed for nutrition and the facility abruptly discontinued an antidepressant medication for 1 of 6 resident (Resident #85) reviewed for unnecessary medications. Findings included: Resident #354 was admitted to the facility on 5-3-21 with multiple diagnoses that included pleural effusion and edema to lower extremities. A review of a physician order dated 10-24-21 read daily weights every day shift for edema. A physician order dated 10-24-21 revealed Resident #354 was receiving Lasix (diuretic) 40mg (milligrams) daily. The quarterly Minimum Data Set (MDS) dated 11-4-21 revealed Resident #354 was severely cognitively impaired. The MDS was not coded for rejection of care. Resident #354's electronic medical record was reviewed and revealed the last weight entered into the record was dated 11-14-21. The facility's weight book was reviewed for November for Resident #354 and was found to have the weights missing for the following dates: November 15, 16, 17, 19, 20, 21, 23, 24, 26 and 29 2021. There was no documentation in the weight book as to why the weights were not documented. Further review of Resident #354's electronic	F 684	omissions of weight on 12/1/21. Daily weights will remain as an active order for this resident. No negative outcome was noted related to the omission of the weights. The Director of Nursing informed the attending Physician about the discontinuation of an antidepressant medication versus reducing the medication as ordered for resident #85 on 12/1/21. The resident was started on Sertraline 50 mg daily on 12/17/21. A medication variance report was completed on 12/20/21 by Assistant Director of Nursing. Resident was seen by psych on 12/20/21 with no changes. There was no significant negative outcome for the resident identified and she is tolerating the antidepressant medication without adverse effects. The nurse responsible for the medication being discontinued versus reduced no longer works in the facility. 2. All residents that have orders for daily weights are at risk for the weight not to be done. All residents with pharmacy recommended antidepressant medication order changes are at risk for recommendations not being implemented as ordered. 3. An order listing report for all daily	

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F 684	Continued From page 15	F 684		

medical record revealed no progress notes related to the missing weights.

The Director of Nursing (DON) was interviewed on 12-1-21 at 10:15am. The DON discussed Resident #354 refusing to be weighed and stated that was why there was no documentation. She further stated the nursing assistance were responsible for obtaining resident weights and should be documenting when Resident #354 refuses.

A telephone interview occurred with nursing assistant (NA) #3 on 12-1-21 at 11:20am. NA #3 confirmed she worked on November 15, 16, 17, 20 and 21st 2021. She acknowledged Resident #354 was on daily weights and stated the resident had not refused his weights. She explained she could not remember receiving a weight for the resident on those days but stated if she had she would have documented the weight in the weight book. NA #3 said there were days when the unit was busy, and she had forgotten to obtain weights.

NA #2 was interviewed on 12-1-21 at 2:25pm. NA #2 confirmed she had been working on the dates the weights were missing in November 2021 and she stated, "it was probably an oversite, but it could have been he refused." She explained Resident #354 did not often refuse weights and said the hall would get busy sometimes and she would forget to obtain the weights.

The facility Physician was interviewed by telephone on 12-1-21 at 12:24pm. The Physician explained Resident #354 was on daily weights for Pleural Effusion and stated the resident's lungs had filled with fluid and the facility was using

weights was reviewed with the attending Physician and any omissions were discussed with the attending physician by the Director of nursing. This was completed on 12/1/21.

Pharmacy recommendations will be reviewed from October 1 forward to audit that any medication order changes were implemented as ordered. This will be completed by 1/5/22 by Assistant Director of Nursing. There were no other discrepancies identified.

4. The Director of nursing or designee will provide education to the dietary manager and current licensed nurses regarding ensuring all residents with daily weights are obtained as ordered and if not obtained reflected in the medical record as to why the order was not followed. Current nursing assistants were educated that they are to follow through with any assignment given to them by the licensed nurse in obtaining daily weights and if the resident refuses or the weight is not obtained they should notify the charge nurse of the refusal. New hires and agency staff will receive this education. This education will be completed by 1/5/22.

The Director of nursing or designee will provide education to the current licensed nurses on accurate implementation of medication orders received from doctor approved pharmacy recommendations. This education will be completed on 1/5/22. New hires and agency staff will

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F 684	Continued From page 16 medication to decrease the amount of fluid in his lungs and the edema (swelling in an extremity) in the residents' lower extremeties. He said he had chosen to keep Resident #354 on daily weights because he was aware the resident's weight was not being obtained everyday and stated if he had moved the resident to weekly weights, he was concerned he would not have a comparable weight weekly. The Physician clarified he was aware weights were not being obtained everyday but expected to see documentation that staff had attempted to obtain a weight daily. 2. Resident #85 was admitted to the facility on 10/17/19 with diagnoses that included depression. Resident #85 ' s Minimum Data Set (MDS) assessment dated 10/21/21, an annual assessment, revealed she was cognitively intact and was coded as feeling down or depressed and having little interest in doing things 7-11 of the last 14 days. A pharmacy consultant recommendation dated 8/18/21 indicated a Gradual Dose Reduction (GDR) of Resident #85 ' s physician ' s order for Sertraline HCl (antidepressant) 75 milligrams (mg) to 50 mg was recommended. The physician indicated he agreed with the recommendation on 8/31/21. A pharmacy consultant recommendation dated 9/19/21 read in part, " ... prescriber accepted a pharmacy recommendation to reduce the Sertraline from 75 mg daily to 50 mg daily on 8/31/21, but the order has not yet been processed. Please process the accepted pharmacy recommendation and update the	F 684	receive this education. 5. The Unit Managers will use a monitoring tool to validate the daily weights are obtained 5 x weekly as part of clinical startup. This will be done for 12 weeks and the results of the audits will be reviewed at QAPI monthly for three months. The Assistant director of nursing will use a monitoring tool to show validation that pharmacy recommendations were implemented per the order 5x weekly as part of clinical start up. This will be done for 12 weeks. The results of the audits will be discussed at QAPI for three months. This plan of correction will be competed as of 1/5/22.	

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F 684	Continued From page 17	F 684		

medical record accordingly." Nurse #6 ' s initials dated 9/28/21 with the word done were found on the bottom of the consultation report.

Review of manufacturers recommendations for Sertraline read in part, "adverse reactions after discontinuation especially after abrupt discontinuation include : nausea, sweating, dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesia, such as electric shock sensations), tremor, anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. A gradual reduction in dosage rather than abrupt cessation is recommended whenever possible

Review of physician orders revealed Resident #85 ' s 75 mg Sertraline (initiated on 8/5/20) was discontinued on 9/28/21 by the physician ' s assistant and entered by Nurse #6.

Record review revealed no progress note detailing the reason for the discontinuation of the Sertraline.

An interview was conducted with the Medical Director on 12/1/21 at 3:13 PM who stated the pharmacy consultant recommended a GDR of Sertraline and he agreed with this recommendation as he usually followed the consultant pharmacist ' s recommendation. He stated that once he approved the recommendations on 8/31/21 it was considered an order within the facility. He stated he expected his order to be followed.

Attempts to interview the physician assistant were unsuccessful.

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F 684	Continued From page 18 An interview was conducted with the Director of Nursing (DON) on 12/2/21 at 10:17 AM and she stated the consultant pharmacist recommendations were emailed to the Assistant Director of Nursing (ADON) who ensured the recommendations were reviewed and implemented as directed by the physician. During an interview with the ADON on 12/2/21 at 10:22 AM she stated she gave the consultant pharmacist recommendations to Nurse #6. She reported when she received pharmacy recommendations, she forwarded them to the Unit Manager to implement. The ADON she did not know why the recommendations were not implemented. An interview was attempted with Nurse #6 on 12/2/21 at 12:14PM and she was unable to be reached. During an interview with the DON on 12/2/21 at 12:23 PM she indicated Nurse #6 should have followed the pharmacy recommendations as revealed in the pharmacy consultant report after they were approved by the Medical Director.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		1/5/22

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F 688	Continued From page 19 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply a splint per the plan of care for 1 of 1 resident reviewed for position/mobility (Resident #73). The findings included: Resident #73 was admitted to the facility on 11/2/16 with diagnoses that included a right-hand contracture and dementia. Resident #73's most recent Minimum Data Set (MDS) assessment dated 10/14/21, an annual assessment, revealed the resident had a severe cognitive impairment and required total assistance with activities of daily living (ADLs). The assessment revealed the resident had impaired range of motion of the upper extremity on one side of the body. There were no refusals of care coded on the assessment. An order dated 3/25/21 stated to place a right upper extremity resting splint to be placed on Resident #73 after her bath and removed end of first shift. Resident #73's care plan dated 11/9/21 noted the	F 688	1. When the Director of Nursing was notified of the splint not being in place on 12/1/21 for resident # 73, she instructed the assigned nursing assistant to apply the splint. 2. All residents with splints have the potential for their splint not to be applied per instructions. 3. An audit was completed of all residents that have a splint by Restorative Aide and completed by 12/2/21 to ensure that splints were available at bedside. An audit will be conducted by Director of Staff Development to ensure splints are on the Kardex and careplan by 1/5/22. 4. The Director of Nursing or designee will provide education to the current licensed nursing staff nursing assistants regarding ensuring splinting schedule are followed as indicated on the Kardex. This education will be completed on 1/5/22 and will be provided to new hires on orienation.	

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F 688	Continued From page 20 resident required an upper extremity resting splint. The intervention was to apply an upper extremity resting splint after morning care and remove it before the end of first shift. Review of the Kardex (a care guide for Nursing Assistants) revealed Resident #73 had a right upper extremity resting splint to be placed after her morning bath and removed at the end of first shift. On 11/30/21 at 8:30 AM, 9:45 AM, and 10:15 AM Resident #73 was observed lying in bed and she did not have a resting splint on her right hand. On 11/30/21 at 1:59 PM Resident #73 was observed lying in bed and there was not a splint on her right hand. On 12/1/21 at 10:22 AM the resident was observed lying in bed. There was not a splint on her right hand. On 12/1/21 at 11:45 AM Resident #73 was observed lying in bed and there was not a splint on her right hand. An interview was conducted with Nursing Assistant (NA) #4 on 12/1/21 at 11:50 AM who stated she was assigned to Resident #73 on that day. She reported she did not know if Resident #73 wore a resting splint and would have to ask therapy staff. She reported that she did not have a regular assignment and would have to clarify with therapy if resident required a splint. NA #4 returned from speaking with therapy staff and stated Resident #73 required a resting splint on her right hand. NA #4 then placed the splint on Resident #73.	F 688	5. Weekly audits of residents with splints will be conducted by Restorative Aide to validate that the splints are on as ordered. This audit will be conducted x 12 weeks and the results presented at QAPI monthly x three months for the months of Jan, Feb & March 2022. This plan of correction will be completed as of 1/5/22.	

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F 688	Continued From page 21 On 12/1/21 at 12:04 the Director of Nursing (DON) stated staff should check the Kardex to determine if a resident needed to wear a splint. She stated a splint should have been placed after morning care.	F 688		
F 690 SS=D	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	F 690		1/5/22

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F 690	Continued From page 22 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent a urinary catheter bag from encountering the floor to reduce the risk of infection or injury. This occurred for 1 of 1 resident (Resident #50) reviewed for urinary catheter. Findings included: Resident #50 was admitted to the facility on 9-15-21 with multiple diagnoses that included benign prostatic hyperplasia and obstructive uropathy. The modified admission Minimum Data Set (MDS) dated 9-22-21 revealed Resident #50 was moderately cognitively impaired and was coded for an indwelling catheter. Resident #50's care plan related to his urinary catheter dated 10-4-21 revealed a goal that he would be free from catheter related trauma. The interventions for the goal were in part, anchor catheter to prevent excessive tension and position catheter bag and tubing below the level of the bladder. An observation of Resident #50's catheter occurred on 11-29-21 at 12:10pm. The observation revealed the catheter bag was hanging under his wheelchair with the bottom of the bag touching the floor.	F 690	1. When the Director of Nursing was informed of Resident #50's urinary catheter bag touching the floor on 12/2/21, she instructed the licensed nurse to change the Foley catheter bag. No known infection or injury was identified related to the identified occurrence. 2. All residents with a catheter are at risk for the catheter to come in contact with the floor. 3. An audit will be completed of all residents that have a urinary catheter bag to ensure it is not in contact with the floor and a new drainage bag applied if indicated. This audit was completed on 12/2/21 by Wing Managers. 4. The Director of Nursing or designee will provide education to the current licensed nursing staff and current nursing assistants and current therapists regarding proper placement of a catheter bag to ensure that the bag does not come in contact with the floor due to the risk of injury or infection. This education will be completed by 1/5/22 and added to orientation for new hires. 5. Random audits of residents with urinary catheters will be conducted weekly	

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F 690	Continued From page 23 Resident #50's catheter was observed on 11-30-21 at 11:55am and revealed the catheter bag was hanging under the resident's wheelchair with the bottom of the bag touching the floor. During an interview with Nursing Assistant (NA) #2 on 12-1-21 at 2:25pm, the NA discussed proper placement of a catheter stating catheters were not to touch the floor and if it could not be avoided then the catheter needed to be placed in a holder so the catheter would not touch the floor. NA #2 said Resident #50's catheter bag was placed under his wheelchair, so she had not noticed the catheter bag had been touching the floor. She explained she had placed the catheter under the resident's wheelchair and a more proper placement should have been behind the resident's wheelchair. The NA explained she felt putting the catheter bag under the wheelchair provided more privacy and did not realize it was touching the ground. Nurse #2 was interviewed on 12-1-21 at 4:00pm. The nurse stated she had not observed the placement of Resident #50's catheter bag so she was unaware the bag had been touching the floor. She explained the NAs usually cared for the catheters unless there was a problem. The Director of Nursing (DON) was interviewed on 12-2-21 at 10:53am. The DON discussed the facility monitoring catheters for touching the floor and for privacy covers but added "when a catheter is hung under the wheelchair it will touch the floor."	F 690	for 12 weeks to ensure proper placement of the catheter bag so that it does not touch the floor. These audits will be conducted by Wing Managers. 6. The results of the audits will be reviewed at QAPI for three months. This plan of correction will be completed on 1/5/22	
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1)	F 742		1/5/22

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F 742	Continued From page 24 §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interview, the facility failed to obtain behavioral health services for 1 of 1 resident (Resident #50) who voiced feelings of depression and paranoid ideations. Findings included: Resident #50 was admitted to the facility on 9-15-21 with multiple diagnoses that included fracture of the scapula (left shoulder), fracture of right lower leg and cellulitis of the right upper limb. The modified admission Minimum Data Set (MDS) dated 9-22-21 revealed Resident #50 was minimally cognitively impaired and was coded as feeling depressed, down or hopeless 2-6 days. There were no behaviors coded. Resident #50's care plan dated 10-4-21 revealed a goal that he would feel better with fewer symptoms of psychosis. The interventions for the goal were in part, administer medications ordered by the physician and refer to psychiatric services.	F 742	1. Resident # 50 has been on trazadone 100mg for his diagnosis of depression since admission on 9/15/21. Resident was admitted to facility on 9/15/21 on Seroquel 50mg. Attending physician reviewed resident□s history and could not find any psychiatric diagnosis or any current behaviors. Attending physician decided to do GDR on 10/2/21 to 25mg and saw resident 10/7/21 and 10/21/21 no behavior concerns. Attending physician then discontinued Seroquel 25mg on 10/24/21 due to resident not having current behaviors. Attending physician had follow up with visit on 11/17/21 with no behavior concerns. Resident was seen by psychiatric nurse practitioner on 12/6/21. There were no medication changes as resident denied any current issues with hallucinatory behaviors or delusions. Resident interview by psych revealed resident was sleeping well. Psychiatric services will continue with resident and adjustments to his plan of care will be made if indicated. Psychiatric services	

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F 742	Continued From page 25 Resident #50 was interviewed on 11-29-21 at 12:10pm. The resident discussed his history stating he used to be independent, living on his own and working until he was walking across the train tracks and was hit by the train. Resident #50 described his injuries and having to be dependent on others. The resident became tearful stating was depressed and did not feel he would ever be able to return to his previous state. Resident #50 began whispering and he stated, "we have to be quiet. They are watching and listening to us." He explained he believed there were cameras in the television where staff watched and listened to him. The resident requested for the cameras to be removed. Resident #50 was observed on 11-30-21 at 11:30am sitting in his room with a flat affect staring at the floor. When approached, the resident stated he could not talk right now and was observed looking up at the television. During an interview with Nursing Assistant (NA) #2 on 12-1-21 at 2:25pm, NA #2 stated Resident #50 often hallucinated by speaking to someone or something that was not there and had discussed with her that he believed there were cameras in his television and staff were watching him. NA #2 explained she would try to reassure the resident there were no cameras in his room, but he would become agitated and yell at her. She stated she could not document the resident's behavior in the computer, but she reported the symptoms to the nurse (Nurse #2). The Social Worker was interviewed on 12-1-21 at 3:02pm. The Social Worker stated Resident #50 was not being seen by mental health and she was	F 742	saw resident again on 12/20/21 with no change of orders. The attending physician visited with the resident on 12/20/21with no noted behaviors and no change of current medicines. The responsible party was given an update on 12/20/21 regarding the psychiatric visit and the visit by the Medical Doctor on 12/20/21. The responsible party indicated that they had not witnessed resident with any hallucinatory behaviors or delusional thinking. 2. All residents that experience changes in their mental health symptoms such as feelings of depression and paranoid ideation should be evaluated as to need for behavioral health services. 3. A PHQ9 and mental health assessment will be completed on all residents by a social service or licensed nurse by 1/5/22. The Medical Doctor will be notified of any significant changes identified with psychiatric consultation if indicated. 4. Current licensed nurses, new hires and agency nurses will be educated regarding notification to the Medical Doctor when they are alerted or identify changes in a resident□s mental health symptoms. This education will include completion of an SBAR progress note. In addition, Nursing Assistants will also be educated regarding notification of Nurse when resident displays mental health	

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F 742	Continued From page 26 unaware of the resident's care plan for a referral to mental health services. She also said she was not aware of his mental health symptoms. The Social Worker expressed she would speak with Resident #50 about mental health services and that she was responsible for arranging the services when the care plan or the issue was brought to her attention. The facility Physician was interviewed by telephone on 12-1-21 at 3:15pm. The Physician discussed Resident #50 being admitted to the facility on Seroquel (antipsychotic medication) from the hospital which was prescribed at bedtime for behaviors. He explained there was little information about Resident #50's mental health and he had discontinued the Seroquel upon admission. The Physician affirmed he had not been made aware of Resident #50's depression or paranoid ideations and stated discontinuing the Seroquel could have unmasked an underlining mental illness. On 12-2-21, Nurse #2 was interviewed at 9:00am. Nurse #2 discussed Resident #50's accident that brought him to the facility and stated she had seen the resident depressed, staring at the floor and never smiling. The nurse stated Resident #50 had not voiced feeling depressed or that there were cameras in his television. Nurse #2 also said she had not been made aware of any mental health symptoms by the nursing assistant. The Director of Nursing (DON) was interviewed on 12-2-21 at 10:53am. The DON stated she was not aware of any mental health symptoms with Resident #50. She explained the nursing assistance can document resident behaviors in the computer which would trigger Social Work to	F 742	symptoms. This education will be provided by the Director of clinical education or Assistant Director of Nursing and will be completed by 1/5/22. 5. As part of clinical daily startup, the SBAR progress notes will be reviewed with validation that the Medical Doctor and responsible party have been notified of changes in residents mental health status. A monitoring tool will be used to record the results weekly of the audits and presented at QAPI for the next 3 months (Jan, Feb, March 2022) to continue to monitor. This plan of correction will be completed by 1/5/22.	

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F 742	Continued From page 27 further investigate. The DON stated she did not know why the nursing assistant was not documenting Resident #50's behaviors in the computer but she would provide education to the staff on proper documentation.	F 742		
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 observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart and failed to	F 761	1. On 11/29/21 the wound nurse identified the 400 hall medication cart was unlocked and she locked the cart. The	1/5/22

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F 761	Continued From page 28 remove loose unsecured medications from a medication cart for 2 of 3 medication carts observed (400 Hall Medication Cart and 300 Hall Medication Cart). Findings included: 1. During observation on 11/29/21 at 11:35 AM the 400 hall medication cart was observed unlocked and unattended at the nursing station. At 11:35 AM, a housekeeping staff member walked by the unlocked medication cart. At 11:36 AM a resident and a nurse aide were observed to walk by the unlocked medication cart. At 11:37 AM a resident went by the unlocked medication cart and again at 11:45 AM another resident passed the unlocked medication cart. At 11:49 AM the Wound Care Nurse observed the unlocked medication cart and locked it. During an interview on 11/29/21 at 11:49 AM the Wound Care Nurse stated medication carts were to be locked when unattended. The 400 hall medication cart was unlocked and should have been locked by Medication Aide #1 before she left it unattended. During an interview on 11/29/21 at 12:27 PM Medication Aide #1 stated medication carts were to be locked when unattended by staff. She concluded she thought she had locked the medication cart prior to leaving it. During an interview on 11/29/21 at 1:56 PM the Director of Nursing stated medication carts were to be locked when unattended. 2. On 12/1/2021 at 11:20 am an inspection was conducted on the 300 hall medication cart. Five loose circular pills (one yellow, one orange, 2	F 761	Director of Nursing provided inservicing to the 400 hall medication nurse regarding ensuring that the medication cart was locked at all times when not in use. The loose pills on 300 and 400 hall carts were discarded by the medication nurse during the medication cart audits on 12/1/21 2. No residents were impacted by the unlocked medication cart and loose pills on the cart but carts should be secured at all times and loose pills discarded promptly from each cart. 3. The Director of Nursing or designee will inservice all licensed nursing staff on ensuring that medication carts are never left unlocked when unattended and that loose pills are should not be on the medication carts. This education will be completed by 1/5/22. New hires and agency staff will receive this education. 4. Random audits will be completed by 1/5/22 weekly across all shifts to ensure the medication carts are locked and that no loose pills are noted in the medication carts. Any observations of concern will be addressed immediately with the nurse responsible for the medication cart at the time of the observation. These audits will be done weekly for 12 weeks and the results of the audits will discussed at QAPI monthly x 3 months. This plan of correction will be completed	

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F 761	Continued From page 29	F 761		

white, and one red) of various sizes were observed to be unpackaged and loose on the bottom of the over the counter medication drawer.

During an interview with Nurse #4 on 12/1/2021 at 11:24 am he stated he was not aware there were loose pills in the medication drawer. He then stated he could not identify the pills right off hand. He said that was his first time working on the 300 hall medication cart and he did not spill any pills in the medication drawer. Nurse #4 was unable to tell how often the medication carts were supposed to be checked for loose medications.

On 12/1/2021 at 11:30 during an interview with Lead Nurse #5 he stated the medication carts were supposed to be checked during and after every shift by the assigned nurse. He then stated the Lead Nurse was supposed to audit the medication cart daily if possible. Lead Nurse #5 stated he did not checked the medication cart the morning of 12/1/2021.

On 12/2/2021 at 10:00 am during an interview with the Director of Nursing (DON) she stated the medication carts were cleaned on 11/29/2021 by the Nurse Consultant. She then stated the nurses were responsible for checking their own medication cart daily for loose pills. She further stated the wing manager or lead nurse was responsible for completing audits behind the nurses. The DON said loose pills should not have been left in the 300 hall medication cart.

by 1/5/22.