STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(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 2/7/22 through 2/11/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZY3W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/7/22 through 2/11/22. 1 of the 21 complaint allegation was substantiated but did not result in a deficiency and 5 of the 21 complaint allegation(s) were substantiated resulting in deficiencies. Event ID# ZY3W11	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		3/11/22

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

Electronically Signed | 03/03/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interviews, the facility failed to treat a resident with dignity who required assistance with eating by standing up to feed the resident during 2 of 4 meals observed for 1 of 2 resident reviewed for dignity. (Resident #7) The findings included: Resident #7 was admitted to the facility on 12/21/18 of age-related osteoporosis and chronic obstructive pulmonary disease. A significant change Minimum Data Set (MDS) dated 10/21/21 coded the resident as being moderately cognitively impaired and was dependent on staff for eating.	F 550	The facility will continue to ensure that residents are treated with dignity when being assisted with eating. Resident #7 will continue to be treated with dignity when being assisted with eating as evidenced by staff sitting at eye level with resident. No negative outcome was identified relating to this observation. Current residents that require assistance with eating have the potential to be affected. Current residents that require assistance with eating (a total of 18 residents) were observed on 2.25.22 by the RSD and DON to ensure that they are being treated with dignity when being assisted with eating. No negative	

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F 550	Continued From page 2 An observation on 2/7/22 at 12:41 PM of Nurse Aide #3 (NA) standing over Resident #7 feeding her. A chair was next to the bed. An observation on 2/9/22 at 8:53 AM of NA #1 standing over Resident #7 feeding her with the privacy curtains pulled. A chair was next to the bed. An observation on 2/9/22 at 5:43 PM of NA #4 sitting next to Resident #7 feeding her. NA #4 said Resident #7 preferred to have someone sit by her while feeding. Resident #7 was asked if she would rather have a NA stand to assist her with feeding or sit next to her and she responded "Sit." An interview was completed with NA #2 on 2/10/22 at 10:07 AM who was assisting Resident #7 on 2/10/22. NA #2 was asked how she assists Resident #7 with feeding. NA #2 stated that she would stand up while feeding Resident #7. The NA stated we would always stand and not sit next to the resident as that was how she was taught. NA #2 stated she stood up to feed Resident #7's morning meal (2/10/22) as she always would stand. An interview was completed with NA #3 on 2/11/22 at 10:56 AM. NA #3 stated that she would take the tray and have the resident sit up in bed. NA #3 was told she was observed standing to feed Resident #7 on 2/7/22 during the lunch meal and was asked why she was standing? NA #3 offered no explanation why she stood to feed Resident #7 on 2/7/22 during the lunch meal. An interview was completed with the Administrator on 2/11/22 at 3:42 PM who stated	F 550	outcome was identified relating to these observations. 100% of all nursing assistants were inserviced by the ADON as of 3.3.22 on ensuring that residents that require assistance with eating are treated with dignity by sitting at eye level with each resident when assisting with eating. Newly hired staff c n a's and agency c n a 's will be educated by the ADON on the facility policy for treating residents with dignity when being assisted with eating by sitting at eye level with each resident upon hire. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 3.7.22. The DON will randomly observe staff assisting 3 residents with eating at each meal 3x/week x 4 weeks then weekly x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the March	

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F 550	Continued From page 3 that he would expect staff should get a chair because mealtime is a social event, so if you can safely feed a resident sitting down you should conduct the assistance sitting down.	F 550	through May regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		3/11/22

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F 578	Continued From page 4 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately document a resident's code status in the electronic medical record (EMR) for 1 of 24 residents (Resident #14) reviewed for advance directives. The findings included: Resident #14 was admitted to the facility on 11/25/21 with a cumulative diagnoses which included schizophrenia. Resident #14's electronic medical record (EMR) included a scanned, signed copy of a goldenrod "Do Not Resuscitate Order" (DNR) dated as effective on 11/25/21. The EMR also included a scanned copy of an "Emergency Response Directive" signed by Resident #14 on 11/25/21 and her physician on 12/7/21. This form indicated the resident did not desire cardiopulmonary resuscitation to be initiated at the facility if she suffered cardiac or respiratory arrest (DNR code status). A review of Resident #14's physician's orders in her EMR included a current order dated 11/26/21 which read, "Full Resuscitation." Resident #14's admission Minimum Data Set	F 578	The facility will continue to accurately document each resident's code status in the electronic medical record. Resident #14's code status was confirmed and corrected in the electronic medical record at the time of discovery by the DON. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. Current resident medical records were audited by the Social Worker on 2.9.22 to ensure that the code status was accurately documented in the electronic medical record. No negative outcome was identified relating to this audit. 100% of licensed nurses were inserviced by the Social Worker on the facility process for ensuring that each resident's code status is accurately documented in the electronic medical record as of 3.3.22. Newly hired staff nurses and agency nurses will be educated by the ADON upon hire on the facility process for accurately documenting each resident's code status in the electronic medical	

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F 578	Continued From page 5 (MDS) dated 12/1/21 revealed the resident had moderately impaired cognitive skills for daily decision making. The assessment indicated she had the ability to make herself understood and to understand others with clear comprehension. On 2/7/22, information included in the top banner of Resident #14's EMR indicated the resident's code status was "Full Code." An interview was conducted on 2/9/22 at 10:30 AM with the facility's MDS Coordinator. Upon request, the MDS Coordinator reviewed the Advance Directive information in Resident #14's EMR and confirmed "Full Code" was indicated on the top of the EMR ' s main screen for Resident #14. However, the also confirmed the resident's EMR included a signed goldenrod DNR form. The MDS Coordinator stated, "that's wrong." An interview was conducted on 2/9/22 at 10:50 AM with the facility's Director of Nursing (DON). During the interview, the discrepancy regarding Resident #14's Advance Directive was reviewed and discussed. The DON described the process employed to designate a new resident's Advance Directive upon admission to the facility. She reported the Advance Directive was initially discussed and signed when the family or resident came in to the facility. If DNR was chosen, the paperwork would be given to the Medical Director for the physician's signature and then it was passed along to the DON to put the order into the EMR. The paperwork would be sent to Medical Records to be scanned into the EMR; the goldenrod DNR form was kept in a binder at the nurses' station. Upon review of the DNR paperwork scanned into Resident #14's EMR, the DON stated, "I've not seen this paper ...I'm going	F 578	record. A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker beginning on 3.7.22. The Social Worker will randomly audit 5 resident electronic medical records weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random electronic medical record audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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F 578	Continued From page 6 to fix it right this minute." The DON stated Resident #14's Advance Directive should have been "do not resuscitate." Accompanied by the DON, an observation was made on 2/9/22 at 11:07 AM of the Advance Directive binder stored at the nurses' station. Resident #14's goldenrod Do Not Resuscitate Order was stored in the binder, designating the resident as having a DNR code status. When asked what her expectation was, the DON stated the paperwork for the DNR should have been given to her (the DON) before being scanned into the resident's EMR so the DNR order would be included in her physician's orders.	F 578		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		3/11/22

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F 636	Continued From page 7 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 636	The facility will continue to complete	

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F 636	Continued From page 8 facility failed to complete an admission Minimum Data Set (MDS) assessment (Resident #58) and an annual MDS assessment (Resident #6) within the required time frames for 2 of 14 comprehensive MDS assessments reviewed. The findings included: 1. Resident #58 was admitted to the facility on 12/11/21 with a cumulative diagnoses which included renal (kidney) insufficiency. Review of Resident #58's admission Minimum Data Set (MDS) revealed the assessment reference date (ARD) was 12/17/21. The assessment was signed as completed on 1/4/22. An interview was conducted on 2/9/22 at 10:30 AM with the MDS Coordinator. During the interview, the MDS Coordinator reported she was recently on a leave of absence so the MDS assessments had been completed by another nurse. Upon review of Resident #58's admission MDS, the Coordinator reported the admission assessment was completed past the due date of 12/24/21. An interview was conducted on 2/9/22 at 11:00 AM with the facility's Director of Nursing (DON). During this interview, the DON stated she would expect the MDS assessments to be completed timely and accurately. 2. Resident #6 was admitted to the facility on 5/22/17 with reentry to the facility on 1/8/21 from a hospital. Her cumulative diagnoses included Alzheimer's disease. Review of Resident 6's annual Minimum Data Set	F 636	admission and annual MDS assessments within the required time frames. Resident #58's admission MDS assessment was completed on 1.4.22. Resident #6's annual MDS assessment was completed on 2.8.22. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. All current residents were audited by the MDS Coordinator on 2.25.22 to ensure that admission and annual MDS assessments were completed within the required time frames. No negative outcomes were identified relating to these audits. The MDS Coordinator was inserviced by the Regional Clinical Coordinator on 2.25.22 on completing admission and annual MDS's within the required time frames. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator beginning on 3.7.22. The Regional Clinical Coordinator will randomly audit 2 admission MDS assessments and 2 annual MDS assessments weekly x 4 weeks, then every other week x 4 weeks, then randomly x 4 weeks to ensure that admission and annual MDS assessments are being completed within the required time frames. Variances will be corrected at the time of audit and additional education provided when indicated.	

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F 636	Continued From page 9 (MDS) revealed the assessment reference date (ARD) was 1/16/22. The assessment was not signed as completed at the time of the review on 2/7/22. An interview was conducted on 2/9/22 at 10:30 AM with the MDS Coordinator. During the interview, the MDS Coordinator reported she was recently on a leave of absence so the MDS assessments had been completed by another nurse. Upon review of Resident #6's annual MDS, the Coordinator reported she had just completed this annual assessment on 2/8/22. She confirmed the assessment was completed past the due date of 1/29/22. An interview was conducted on 2/9/22 at 11:00 AM with the facility's Director of Nursing (DON). During this interview, the DON stated she would expect the MDS assessments to be completed timely and accurately.	F 636	Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of admission and annual MDS assessments and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time for 1 of 8 quarterly MDS assessments reviewed (Resident #33). The findings included:	F 638	The facility will continue to complete quarterly MDS assessments within the required time frame. Resident #33's quarterly MDS assessment was completed on 2.15.22. No negative outcome was identified	3/11/22

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F 638	Continued From page 10 Resident #33 was admitted on 10/28/21 with a cumulative diagnoses which included diabetes. Review of the Minimum Data Set (MDS) assessment for Resident #33 revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/17/22 was not completed. An interview was conducted on 2/9/22 at 10:30 AM with the MDS Coordinator. During the interview, the MDS Coordinator reported she was recently on a leave of absence so the MDS assessments had been completed by another nurse. Upon review of Resident #33's quarterly MDS dated 1/17/22, the Coordinator confirmed this assessment "hadn ' t been done yet" and was late. She reported the due date of the assessment would have been 1/31/22. An interview was conducted on 2/9/22 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect the MDS assessments to be completed timely and accurately.	F 638	relating to this observation. Current residents have the potential to be affected. All current residents were audited by the MDS Coordinator on 2.25.22 to ensure that quarterly MDS assessments were completed within the required time frame. No negative outcomes were identified relating to these audits. The MDS Coordinator was inserviced by the Regional Clinical Coordinator on 2.25.22 on completing quarterly MDS's within the required time frame. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator beginning on 3.7.22. The Regional Clinical Coordinator will randomly audit 3 quarterly MDS assessments weekly x 4 weeks, then every other week x 4 weeks, then randomly x 4 weeks to ensure that quarterly MDS assessments are being completed within the required time frame. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of quarterly MDS	

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F 638	Continued From page 11	F 638	assessments and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	
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 (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)-	F 656		3/11/22

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F 656	Continued From page 12 (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, observations resident and staff interviews, the facility failed to develop a care plan with interventions and goals for a resident who smoked for 1 of 1 resident reviewed for accidents. (Resident #61) The finding included: Resident #61 was admitted to the facility on 10/14/21 with a diagnosis of encounter of other orthopedic aftercare. A baseline care plan was completed on 10/14/21 revealed no goals or interventions for Resident #61 for smoking. Resident #61 Minimum Data Set (MDS) admission assessment dated 10/20/21 specified the resident's cognition was mildly impaired. Health conditions related to tobacco use was marked Yes on the MDS assessment. The care plan dated 10/25/21 did not identify any interventions or goals related to Resident #61's smoking or tobacco use.	F 656	The facility will continue to ensure that care plans are developed with interventions and goals for residents who smoke. Resident #61 had a care plan developed with interventions and goals for smoking at the time of discovery on 2.9.22. No negative outcome was identified relating to this observation. Current residents that smoke have the potential to be affected. Care plans of all current residents that smoke were audited by the MDS Coordinator on 2.9.22 to ensure that care plans had been developed with interventions and goals for smoking. No negative outcome was identified relating to these audits. The MDS Coordinator was inserviced by the Regional Clinical Coordinator on 2.25.22 on developing care plans with interventions and goals for residents that smoke.	

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F 656	Continued From page 13 Resident #61's medical record revealed a smoking assessment was completed on 10/25/21 and required Resident #61 to be supervised when smoking. An observation of Resident #61 smoking on 02/8/22 at 04:00 pm was conducted. Resident #61 stated he goes out to smoke during the scheduled smoking times at the facility. An interview was completed on 2/9/22 at 3:07 PM with the facilities Social Worker (SW). She was asked why smoking was not completed on Resident #61's care plan. The SW stated that if a resident smokes, it should be included on the care plan and the MDS nurse is responsible for documenting smoking on the care plan. An interview was conducted on 2/9/22 at 3:30 PM with the facility's MDS Nurse who was asked to look at Resident #61's care plan for smoking. During the interview, the MDS Nurse stated that she did not see smoking on the care plan, and it should have been. The MDS Nurse stated this was an oversite and it would be her expectation that it should have been on care plan when he was admitted and if not MDS staff should have caught it as smoking was included on the MDS assessment. An interview was completed with the Administrator on 2/11/22 at 3:42 PM who stated the care plan should properly identify a resident who smokes as a smoker.	F 656	A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator beginning on 3.7.22. The Regional Clinical Coordinator will randomly audit care plans of 2 residents that smoke weekly x 4 weeks, then every other week x 4 weeks, then randomly x 4 weeks to ensure that care plans are being developed with interventions and goals for smoking. Variances will be corrected at the time of audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months (regularly scheduled March through May meetings) or until resolved and additional education/training will be provided for any issues identified.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/11/22

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F 677	Continued From page 14 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure a resident's hair and nails were clean (Resident #34) and teeth were brushed (Resident #7) for 2 of 14 residents reviewed who were dependent on staff for their Activities of Daily Living (ADLs). The findings included: Resident #34 was admitted to the facility on 8/4/20 with a cumulative diagnoses which included non-Alzheimer's dementia. A quarterly Minimum Data Set (MDS) assessment dated 12/21/21 indicated Resident #34 had moderately impaired cognitive skills for daily decision making. No rejection of care nor behaviors were reported. The assessment indicated Resident #34 was independent with eating. The resident required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Resident #34's care plan included the following area of focus: The resident has an Activities of Daily Living (ADL) self-care performance deficit and requires assistance with ADLs and mobility related to impaired cognitive status, decreased mobility, pain and discomfort. There may be fluctuating ability to participate with ADLs due to dementia (initiated on 8/4/20; revised on 6/23/21). A review of the electronic documentation for	F 677	The facility will continue to ensure that residents hair and nails are clean and teeth are brushed. Resident #34 received assistance to wash hair and trim/clean nails at the time of discovery on 2.9.22, per c n a as directed by DON. Resident #7 received assistance with oral care at the time of discovery on 2.9.22, per c n a as directed by DON. No negative outcome was identified relating to these observations. Current residents that require assistance with washing hair, trimming/cleaning nails, and oral care have the potential to be affected. All current residents that require assistance with washing hair, trimming/cleaning nails, and oral care were observed by the DON, ADON, and RSD during adl care by c n a's to ensure that each received assistance with washing hair, trimming/cleaning nails, and oral care as needed. These observations were made between 2.25.22 – 3.3.22. No negative outcome was identified relating to these observations. 100% of nursing assistants were inserviced by the ADON as of 3.3.22 on facility expectations for providing assistance to residents that require assistance with washing hair,	

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F 677	Continued From page 15 showers/baths provided for Resident #34 from 1/1/22 to the date of the review was conducted. The resident was reported as having received a shower/bath on 1/14/22, 1/17/22, and 2/3/22. She was documented as having refused a shower/bath on 1/6/22 and 1/20/22. An observation was conducted on 2/7/22 at 1:12 PM of the resident as she was lying in bed. Her hair was medium length and appeared oily/dirty. Her fingernails were approximately 1/8 inches (") long. A second observation was conducted of Resident #34 on 2/8/22 at 10:30 AM. At that time, the resident was awake and alert but had difficulty answering questions when asked. Her hair was not groomed and appeared oily/dirty. An observation of Resident #34's fingernails on both hands revealed there was a dark brown/black substance underneath each nail. On 2/8/22 at 2:35 PM, the resident was again observed to have her hair unkept with an oily/dirty appearance. Her fingernails on both hands were observed to have a dark brown substance under them. On 2/9/22 at 8:10 AM, an observation revealed Resident #34 was lying in bed awake and alert. Her hair appeared to be unkept and oily/dirty. The resident's fingernails were approximately 1/8" long with a dark brown/black substance under them. When asked if she liked to have her nails manicured, she stated she did. Upon request, the facility's Director of Nursing (DON) was accompanied to Resident #34's room on 2/9/22 at 8:12 AM to observe Resident #34's hair and nails. After observing the resident,	F 677	trimming/cleaning nails, and oral care. Newly hired staff nursing assistants and agency nursing assistants will be educated by the ADON upon hire on the facility expectations for providing assistance to residents that require assistance with washing hair, trimming/cleaning nails, and oral care. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning 3.7.22. The DON will randomly observe 4 residents during care 3 times weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks to ensure that assistance is being provided to residents that require assistance with washing hair, trimming/cleaning nails, and oral care. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months (during routinely scheduled March – May meetings) or until resolved and additional education/training will be provided for any issues identified.	

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inquiry was made as to what the DON's thoughts and expectations were with regards to the care of the Resident #34's hair and nails. The DON responded by stating, "She needs her hair washed and her nails trimmed and cleaned."

2. Resident #7 was admitted to the facility on 12/21/18 of age-related osteoporosis and chronic obstructive pulmonary disease.

A review of the Resident #7's most recent care plan revised on 8/3/2021 revealed a focus area for Activities of Daily Living (ADL) care performance deficit and requires assistance with ADL's due to Cerebral Palsy, decrease mobility and contracture of hands. The interventions included 1 person assistance with personal hygiene and oral care.

Minimum Data Set (MDS) dated 10/21/21 coded the resident as being moderately cognitively impaired and was dependent on staff for personal hygiene.

A review of Resident #7's most recent dental visit on 1/11/22 revealed that Resident #7 had heavy plaque and calculus (a hard calcified deposit that forms and coats the teeth and gums) and inflammation. Recommendations were to see every 2- months.

A phone interview on 2/8/22 at 10:38 AM with Resident #7's representative stated that she did not believe Resident #7 was not getting help with brushing her teeth as when she had visited Resident #7's teeth did not look good, and her teeth seemed to be coated with film.

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On 2/9/22 at 8:30 AM Resident #7 was asked if the staff brush her teeth and she stated "No, they do not." Resident #7 was asked if she had a toothbrush and she said she did not think so. An observation of Resident #7's teeth revealed her teeth were brown with a brown coating.

On 2/9/22 at 10:09 AM Resident #7 was asked if she had her cares completed for the morning and she stated they will be done after lunch as she had bingo today. Resident #7 was asked if she tells the staff to brush her teeth and she stated sometimes she does not like it because having her teeth brushed hurt.

An observation and interview were completed with Resident #7 and Nurse Aide (NA) #1 on 2/9/22 at 1:29 PM. Resident #7 had her personal hygiene completed and was dressed and sitting up in her chair. NA #1 was asked if she brushed Resident #7's teeth and she said no, and then asked Resident #7 if she wanted her teeth brushed and Resident #7 replied "Yes." The NA took an electric toothbrush from Resident #7's bedside table. NA #1 was asked why she did not brush Resident #7's teeth and she stated that brushing teeth is not really an option as most residents have dentures.

On 2/10/22 at 10:07 AM Resident #7 had her shower and was dressed an in her wheelchair. NA #2 was asked if all of her cares had been completed and NA #2 stated yes and was finishing making Resident #7's bed. NA #2 was interviewed outside of the Resident #7's room and was asked if she brushed Resident #7's teeth. NA #2 stated; "No, her teeth look bad to me." NA #2 offered no explanation why oral care

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F 677	Continued From page 18 was not offered or provided to Resident #7. An Interview was completed with the Director of Nursing (DON) on 2/11/22 at 3:22 PM who stated oral care should be done as anyone would for themselves, even if a resident did not have any teeth. An interview was completed with the Administrator on 2/11/22 at 3:42 PM who stated oral care should be offered daily, and residents have rights, they can decline and if they do decline it should be documented in their record, but oral care is a must.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility failed to 1) accurately document assessments and initiate treatment orders for a left buttock stage 2 pressure ulcer in 1 of 3 residents (Resident #215)	F 686	The facility will continue to ensure that accurate pressure ulcer assessments are completed, pressure ulcer treatment orders are initiated appropriately, and pressure ulcer treatments are completed	3/11/22

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F 686	Continued From page 19 and 2) ensure wound care treatments were completed as ordered for 1 of 3 residents (Resident #51) reviewed for pressure ulcer care and prevention. The findings included: 1. Resident #215 was admitted on 12/31/2021 with diagnoses that included aftercare following joint replacement surgery, COVID 19 and a history of a stage 2 sacral pressure ulcer that was present on admission. A review of the Minimum Data Set (MDS) dated 1/6/2022 revealed the Resident was cognitively intact for decision making with confusion and required extensive assistance of two staff members for bed mobility, transfers, and toilet use. A review of the care plan dated 1/6/2022 revealed an identified focused area that read: Resident #215 was at risk for impaired skin integrity/pressure injury related to recent hip fracture and limited mobility. The interventions included to conduct weekly head to toe skin assessments. A review of the admission documentation for Resident #215 identified a surgical wound to the right hip on 12/31/2021 and documented a blister to the left heel. A review of the nurse progress note for 1/1/2022 was conducted and revealed the Resident refused to allow the nurse to remove dressings to her wounds for an assessment on 1/1/2022. A review of the treatment nurse documentation	F 686	as ordered. Residents #215 and #51 have had accurate pressure ulcer assessments completed, pressure ulcer treatment orders are in place, and pressure ulcer treatments are being completed as ordered. No negative outcome was identified relating to these observations. 3/3/22 Currents residents with pressure ulcers have the potential to be affected. Current residents with pressure ulcers were reviewed to ensure that they have accurate pressure ulcer assessments completed, pressure ulcer treatment orders initiated appropriately, and pressure ulcer treatments completed as ordered. No negative outcomes were identified relating to these observations. 3/3/22 The wound care treatment nurse was inserviced by the DON on facility expectations that residents with pressure ulcers have accurate pressure ulcer assessments completed, pressure ulcer treatment orders initiated appropriately, and pressure ulcer treatments completed as ordered. 3/3/22 All licensed nurses were inserviced by the DON on facility expectations that residents with pressure ulcers have accurate pressure ulcer assessments completed, pressure ulcer treatment orders initiated appropriately, and pressure ulcer treatments completed as	

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F 686	Continued From page 20 titled, Skin and wound evaluation, identified the following wounds: Pressure Ulcer (PU) Wound #1: left heel unstageable pressure ulcer present on admission documented on the date of 1/3/2022. PU Wound #2: Right heel deep tissue injury present on admission documented on the date of 1/3/2022. PU Wound #3: Left buttock stage 2 pressure ulcer documented on the date of 1/4/2022. PU Wound #4: Right buttock stage 2 pressure ulcer documented on the date of 1/25/2022. A review of the Physician orders revealed an order for the following: Float heels while in bed every shift 1/1/2022. Wear heel protectors while in bed ordered 1/2/2022. Skin Prep both heels daily in the afternoon for pressure ulcer prevention. Start date 1/2/2022. Refer Resident #215 to the wound Doctor for a wound care treatment plan. Start date 1/5/2022 and signed as completed on 1/6/2022. Cleanse right buttock with Normal Saline, cover with Opti foam dressing in the morning, start date 1/6/2022 and discontinue 1/11/2022. Cleanse the right buttock wound with Normal Saline, cover with Opti foam dressing, and change every 7 days and as needed (PRN) in the morning. The start date was 1/18/2022.	F 686	ordered. 3/3/22 A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit all current pressure ulcer assessments weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks to ensure that accurate pressure ulcer assessments are completed. Variances will be corrected at the time of audit and additional education provided when indicated. 3/7/22 A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit all current pressure treatment orders 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then randomly x 4 weeks to ensure that pressure ulcer treatment orders are initiated appropriately. Variances will be corrected at the time of the audit and additional education provided when indicated. 3/7/22 A QA monitoring tool will be utilized to ensure ongoing compliance by the DON. The DON will randomly audit all current pressure ulcer treatment records 5x/week x 2 weeks the 3x/week x 2 weeks then weekly x 4 weeks then randomly x 4 weeks to ensure that pressure ulcer treatments are completed as ordered. Variances will be corrected at the time of audit and additional education provided when indicated. 3/7/22 Audit results will be reported to the administrator weekly for the next 3	

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F 686	Continued From page 21 A review of the Nurse practitioner (NP) #1's progress note dated 1/6/2022 read right buttock wound, unstageable, tolerating wound care, will be followed by wound care MD. The plan for the right buttocks wound was to continue current wound care and to be followed by the wound MD. A review of the NP #2's progress note dated 1/11/2022 read Sacral pressure ulcer stage 2 and right ankle pressure ulcer stage 2, with dressing dry and intact followed by wound care. A review of NP #2's progress note dated 1/17/2022 read Sacral ulcer stage 2 followed by the Wound MD (Called the wound MD by name) with daily dressing changes. A review of the Wound MD documentation for the date of service 2/7/2022 documented 2/7/2022 was the first visit with Resident #215. He assessed Wound #1 and documented the wound required debridement of eschar for an unstageable heel wound and recommended a new treatment plan and to be reseen in 7 days by the wound team. An interview was conducted on 2/9/2022 with NP #2 and she revealed, related to skin and pressure related wound care, it was the practice of the facility and the medical director to manage the Stage I and sometimes Stage II wounds through the wound care protocol prior to making a referral to the Wound care MD. She stated in the case of an unstageable wound, it would typically be referred automatically. She stated in the case of Resident #215, it was her understanding that the wound care nursing team had consulted the Wound care MD at least one time during the Resident's wound care at the facility prior to	F 686	months and concerns will be reported to the Quality Assurance Committee during monthly meetings. 3/11/22 Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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2/7/2022.

An observation was conducted on 2/9/2022 at 3:02 PM with Nurse #4 of wound care for Resident #215. The nurse gathered the supplies for the left heel wound and stated the Wound care MD had debrided the wound on 2/7/2022 and this was the first time he had treated Resident #215. She was observed to conduct hand hygiene, don a mask, gloves, and goggles. She then knocked on the door, entered the room, explained the procedure, and set up supplies. The nurse assessed the pain level of the Resident and removed the old kerlix dressing for the left heel. She then removed her gloves, preformed hand hygiene, and donned a new pair of gloves. The wound was cleansed with normal saline, dried with gauze and betadine was applied and the wound was wrapped with a kerlix. The Nurse revealed that a referral to the wound MD was ordered the first week of January by the NP (NP #1) and the current wound treatment nurse stated that was not the protocol for the facility and the referral would not be necessary at that time. A dressing was in place to the sacral region of the Resident and the Nurse stated it was not time to change the dressing at this time because it was an every 7-day dressing change.

An interview was conducted with the Regional Clinical consultant (RCC) on 2/9/2022 at 3:42 PM and the RCC opened the TAR for Resident #215 and stated she identified one pressure wound based on the TAR and the physician orders. She opened the Skin and wound evaluations documented during January 2022 and February 2022 and stated she identified 4 pressure wounds, one to the left heel, one to the right heel, one to the right buttock and one to the left buttock

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based on the assessments completed by the wound care treatment nurse. The RCC stated, based on the documentation, she will need to provide education to the treatment nurse on entering orders for wounds, identifying and selecting the treatment of wounds based on the facility wound care guidelines, documentation of notification of the MD, responsible party and administrative team. She added she had scheduled training for wound care and would make an effort to include the wound care treatment nurse for this facility when she returned from a vacation.

2/9/2022 at 3:52 PM an interview was conducted with Director of Nursing (DON). The DON was present during the interview with the RCC and she added it was her expectation that the correct order for the correct wound be entered in the electronic medical record and be documented on the TAR. She stated that if a hall nurse identified a wound, they should then see if an order was in place for the wound. If no order was in place the MD should be notified and the protocol implemented, or a new order be obtained from the MD. The orders should then be entered and documented on the TAR. She revealed her expectation was for the entire nursing team to identify a concern or wound, assess the wound, notify the MD, document the assessment, MD notification and orders. She revealed this was not the role of the wound care nurse alone.

2/10/2022 at 10:31 AM a second interview was conducted with the RCC and she revealed, when reviewing the wound care guidelines for the facility, under the heading, an alteration in skin integrity for intact compromised skin, the wound should be cleansed with wound cleanser, then

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apply sure prep rapid dry, every day and as needed and also off load as appropriate. She revealed the treatment nurse was new to the facility and started in December 2021. She stated she does not agree with the assessment for the right heel and would have expected a note to clarify why it was a deep tissue injury or for the wound care nurse to seek advice from her supervisor. She stated the DON was providing guidance to the wound care nurse and had been out of the facility at the end of December 2021 and again a few weeks in December 2022 due to personal reasons and illness. It was during this time, based on her assessment of the information she reviewed, that inaccuracies in documentation occurred. She stated she feels education was the number one thing needed in this situation. When asked why a nurse that required wound care treatment education was allowed to be in a role that required education, she stated she was training in Med Line and through zoom online. She added the DON and the ADON was responsible for the on-site training. She revealed the ADON had not received specialized wound care training and would not be qualified to conduct wound care training therefore the DON and Medline had been the wound care nurse's resources.

2/10/2022 at 12:04 PM An interview was conducted with the wound care treatment nurse via telephone, and she revealed she began employment with the facility in December 2021 and received training via online resources titled, Med line, through zoom and by following an agency nurse for one week. She stated she had no experience as a skilled nursing treatment nurse or in a skilled medical facility but had been trained to perform wound care in a home health

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setting. She added that her job duties included full time wound care duties and to work as the facility house supervisor that included admissions, discharges, lab work and other responsibilities. Upon review of the documentation of the TAR and the wound assessment documentation for Resident #215 she stated she felt she had made an error in documentation for anatomical placement of left and right. When asked if there had been multiple locations of wounds to the sacral area and buttocks, she stated, "yes, and I resolved some of the wounds." When asked if she provided treatment to all of the wounds on the sacral area and buttocks using the one order on the TAR, she revealed she must have because she treated all wounds, and they would have required the same treatment protocol. She stated, regarding the 1/5/2022 wound care MD referral for treatment that she had informed the ordering nurse to not enter the order because this was not the protocol of the facility. She added that she instructed nurse # 4 to discontinue the order. She denied being aware the order had been placed by NP #1 and that the order was not discontinued. She stated the facility practice for a referral to the wound MD was for a copy of the referral to be provided to the administrative team, including herself and the wound MD would be notified. She stated she did not notify the Wound MD of this referral and was not sure if another nurse had.

2. Resident #51 was admitted to the facility on 9/30/2021 with diagnoses that included a progressive neurological condition, hypertension, diabetes mellitus II, and hemiplegia.

A review of the quarterly MDS dated 1/6/2022 revealed Resident #51 had moderate cognitive

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impairment, a stage 3 pressure ulcer to the right buttock and a stage 4 pressure ulcer to the sacral region and required assistance with pressure ulcer treatments and extensive assistance with activities of daily living that included bed mobility, transfers, dressing, toilet use and personal hygiene.

A review of the care plan dated 10/21/2021 revealed focused areas that read, 1) Resident #51 was at risk for impaired skin integrity and pressure injury related to decreased mobility with interventions that included to conduct weekly head to toe skin assessments, document and report abnormal findings to the physician, observe the wound care dressing frequently to ensure it was intact and adhering to the wound, report a loose dressing to the nurse. 2) Resident #51 was at risk for complications related to an infection of the sacral wound with interventions that included administer medications and treatments as ordered and observed for new or worsening signs and symptoms and report to the physician as needed.

A review of the physician orders for Resident #51 revealed two orders to 1) cleanse the right buttock with normal saline, apply med honey, cover with a dry dressing in the mornings every day started on 11/27/2021 and 2) cleanse the sacrum with normal saline, pack with betadine-soaked gauze, cover with a boarder gauze every morning started on 11/9/2021.

A review of the electronic medical record revealed Resident #51 was diagnosed with a new onset of Osteomyelitis of the sacral area from a Magnetic Resonance Imaging (MRI) study conducted on 1/5/2022.

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A review of the TAR for January 2022 and February 2022 revealed no documentation for completion of the two treatment orders on the dates of 1/3/22, 1/7/22, 1/14/22, 1/15/22, 1/19/22, 1/20/22, 1/25/22, 1/26/22, 1/27/22, 1/28/22, 2/1/22, 2/3/22, and 2/5/22.

On 2/8/2022 at 5:17 PM an interview was conducted with Nurse #1, and she revealed she was the hall nurse on 2/5/2022 for Resident #51 and there had not been a treatment nurse available on the date. She added that her assignment had an emergency for a Resident during the shift and she had been unable to access some wound care supplies that had been locked in the supply closet. She stated if she had completed wound care for Resident # 51, she would have signed the TAR and therefore had not completed the wound care.

An observation was conducted of the wound care treatment on 2/9/2022 at 10:18 a.m. with Nurse # 4. The nurse was observed to gather the supplies, conduct hand hygiene, don a mask, goggles, and gloves, enter the room and update Resident #51 of the procedure. The Nurse conducted a pain assessment and then performed incontinence care to the Resident and removed the dressing from the sacral wound. She removed the soiled gloves, washed her hands, and donned a new pair of gloves. The nurse cleansed the wound with normal saline, packed the wound using a sterile cotton swab applicator, covered the dressing with a boarder gauze and repositioned the Resident with a reminder to try to stay off of the wound. She revealed on Monday, 2/7/2022 when making rounds with the wound care MD she had

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observed a dressing dated 2/4/2022 on the Resident.

An interview was conducted with the DON on 2/9/2022 and she revealed the nursing team had expressed concerns to her that they were unable to complete all of the treatments for their assignment with the previously assigned responsibilities. She did not provide a solution that was offered to the nursing team.

On 2/10/2022 an interview was conducted with Nurse #2 at 3:55 p.m. and she revealed she was the hall nurse for Resident #51 on the dates of 2/26/22, 2/27/22, 2/28/22, 2/1/22, and 2/3/22 and she did not sign the TAR for this Resident and would have signed it if the treatment had been completed. She revealed since the new treatment nurse had begun the hall nurses had been responsible for their wounds and their medications in addition to admissions. She stated the supervisor was responsible for admissions in the past but during January and February 2022 the hall nurse had been doing their own admissions, discharges, and wounds because no one had been available to assist. She revealed it was her practice to sign orders/treatments on the TAR as she completes the task. She added she had not been able to get everything completed in the day and the DON had been reported to regarding the situation.

On 2/10/2022 at 6:09 p.m. an interview was conducted with a coworker of the facility wound care MD, because he was unavailable for interview at the time of the survey, and the consulting MD stated, if an MD writes an order for wound care on a daily basis, the expectation would be for this to be completed daily. He

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F 686	Continued From page 29 conducted a review of the electronic medical record and documentation and revealed the sacral wound for Resident #51 had been improving between the dates of service of 1/21/2022 and 2/7/2022.	F 686		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and 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, staff interviews, and record reviews, the facility failed to: 1) Date opened (in use) injectable medications to allow	F 761	The facility will continue to date opened (in use) medications to allow for the determination of a shortened expiration	3/11/22

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F 761	Continued From page 30 for the determination of a shortened expiration date in accordance with the manufacturer's instructions in 1 of 2 medication carts observed (100/300 Hall Med Cart); and 2) Store medications in accordance with the manufacturer's storage instructions in 1 of 2 medication carts observed (200 Hall Med Cart). The findings included: 1-a) In the presence of Nurse #2, an observation was conducted of the 100/300 Hall Med Cart on 2/7/22 at 3:20 PM. The observation revealed 1-opened Lantus Solostar insulin pen dispensed for Resident #61 was stored on the med cart inside of a plastic bag. The observation revealed neither the insulin pen nor the bag it was stored in was dated as to when the insulin was placed on the med cart and/or opened (put into use). When asked, Nurse #2 confirmed the insulin pen was not dated. The nurse stated she would usually write on the bag or the insulin pen itself as to when the pen had been opened. A review of the manufacturer's storage instructions indicated once punctured (opened), Lantus prefilled insulin pens should be stored at room temperature and used within 28 days. A review of Resident #61's February 2022 Medication Administration Record (MAR) revealed he had a current order for 15 units of Lantus insulin to be injected subcutaneously once daily at bedtime for diabetes. An interview was conducted on 2/9/22 at 8:02 AM with the facility's Director of Nursing (DON) in the presence of the Regional Clinical Coordinator. The findings of the Medication Storage task were	F 761	date in accordance with manufacturer's instructions. The facility will continue to store medications in accordance with the manufacturer's storage instructions. The insulin pens for Residents #61, #2, and #42 were discarded at the time of discovery on 2.7.22. The Cosentyx for Resident #12 was discarded at the time of discovery on 2.7.22. No negative outcome was identified as a result of these observations. All other medication carts were checked at the time of discovery on 2.7.22 by the ADON and RCC. No negative outcome was identified as a result of these observations. All drugs and biologicals will be labeled and stored according to facility policy. Medication carts will be randomly inspected to ensure compliance. 100% of licensed nurses were inserviced by the DON on the facility policy for labeling and storage of drugs and biologicals as of 3.3.22. Newly hired staff nurses and agency nurses will be educated by the ADON on the facility policy for labeling and storage of drugs and biologicals upon hire. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON beginning on 3.7.22. The DON will randomly observe 2 medication carts weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks.	

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F 761	Continued From page 31 discussed during the interview. When asked, the DON stated she would expect insulin pens to be dated when they were put on the med cart and/or opened. 1-b) In the presence of Nurse #2, an observation was conducted of the 100/300 Hall Med Cart on 2/7/22 at 3:20 PM. The observation revealed 1-opened insulin glargine pen dispensed for Resident #2 was stored on the med cart inside of a plastic bag. The observation revealed neither the insulin pen nor the bag it was stored in was dated as to when the insulin was placed on the med cart and/or opened (put into use). When asked, Nurse #2 confirmed the insulin pen was not dated. The nurse stated she would usually write on the bag or the insulin pen itself as to when the pen had been opened. A review of the manufacturer's storage instructions indicated once punctured (opened), insulin glargine prefilled insulin pens should be stored at room temperature and used within 28 days. A review of Resident #2's February 2022 Medication Administration Record (MAR) revealed she had a current order for 10 units of insulin glargine to be injected subcutaneously once daily at bedtime for diabetes. An interview was conducted on 2/9/22 at 8:02 AM with the facility's Director of Nursing (DON) in the presence of the Regional Clinical Coordinator. The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect insulin pens to be dated when they were put on the med cart and/or opened.	F 761	Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 3.11.22 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random medication cart inspections and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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1-c) In the presence of Nurse #2, an observation was conducted of the 100/300 Hall Med Cart on 2/7/22 at 3:20 PM. The observation revealed 1-opened aspart insulin pen dispensed for Resident #61 was stored on the med cart inside of a plastic bag. The observation revealed the insulin pen was not dated as to when it was placed on the med cart and/or opened (put into use). When asked, the nurse confirmed the insulin pen was not dated. A pharmacy auxiliary sticker placed on the bag was blank and was not dated as to when the insulin pen was placed on the med cart and/or opened. Upon inquiry, Nurse #2 reported she thought the sticker typically placed on the pen (which indicated the date the pen was opened) probably fell off.

A review of the manufacturer's storage instructions indicated once punctured (opened), aspart insulin prefilled pens should be stored at room temperature and used within 28 days.

A review of Resident #61's February 2022 Medication Administration Record (MAR) revealed he had a current order for aspart insulin to be injected subcutaneously before meals and at bedtime using a sliding scale regimen (where the dose is based upon the blood glucose or sugar level).

An interview was conducted on 2/9/22 at 8:02 AM with the facility's Director of Nursing (DON) in the presence of the Regional Clinical Coordinator. The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect insulin pens to be dated when they were put on the med cart and/or opened.

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1-d) In the presence of Nurse #2, an observation was conducted of the 100/300 Hall Med Cart on 2/7/22 at 3:20 PM. The observation revealed 1-opened Basaglar Kwikpen dispensed for Resident #42 was stored on the med cart inside of a plastic bag. The observation revealed a pharmacy auxiliary sticker placed on the insulin pen itself was not dated as to when the insulin pen was placed on the med cart and/or opened. Also, the plastic bag the pen was stored in was not dated to indicate when the pen had been opened. When asked, Nurse #2 confirmed the insulin pen was not dated. The nurse reported she thought the sticker typically placed on the plastic bag (which indicated the date the pen was opened) probably fell off.

A review of Resident #42's February 2022 Medication Administration Record (MAR) revealed he had a current order for 20 units of Basaglar insulin to be injected subcutaneously once daily at bedtime for diabetes.

An interview was conducted on 2/9/22 at 8:02 AM with the facility's Director of Nursing (DON) in the presence of the Regional Clinical Coordinator. The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect insulin pens to be dated when they were put on the med cart and/or opened.

2) On 2/7/22 at 3:50 PM, an observation was made of the 200 Hall Med Cart with Nurse #3. The observation revealed an unopened manufacturer box containing two pens of 150 milligrams (mg)/milliliter (ml) Cosentyx (an injectable medication which may be used to treat

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psoriasis) dispensed for Resident #12 on 12/21/21 was stored on the medication cart at room temperature. The storage instructions on the manufacturer's box indicated in bold print that the Cosentyx pens should be stored refrigerated at 2-8 degrees Centigrade (36-46 degrees Fahrenheit) in the original carton to protect them from light. Upon inquiry, Nurse #3 reported the Cosentyx pens would usually be stored in the refrigerator. She reported they were typically delivered to the facility from the pharmacy 1-2 days before the injection of the medication was to be administered.

A review of Resident #12's February 2022 Medication Administration Record (MAR) revealed he had a current order for 300 mg Cosentyx to be administered subcutaneously in the morning every 4 weeks for psoriasis.

An interview was conducted on 2/9/22 at 8:02 AM with the facility's Director of Nursing (DON) in the presence of the Regional Clinical Coordinator. The findings of the Medication Storage task were discussed during the interview. The DON reported the facility was unable to determine how long the box of Cosentyx had been stored at room temperature on the med cart so had to discard this medication. The DON stated it was the hall nurse's responsibility to store medications in accordance with the manufacturer's instructions when they were delivered to the facility by the pharmacy's representative.