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	345013	A. BUILDING _____ B. WING _____	C 09/29/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/26/22 through 09/29/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZXWZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/26/22 through 09/29/22. Event ID# ZXWZ11. The following intakes were investigated NC00192735, NC00193225, NC00192696, NC00190880, NC00190651, NC00192354, NC00191361, NC00190493, NC00190489, and NC00193513. 28 of the 28 complaint allegations were unsubstantiated.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		11/11/22

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

Electronically Signed | 11/02/2022

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F 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews with residents who attended Resident council, and staff interviews, Resident Council minutes, and a Resident Council meeting, the facility failed to resolve a repeat grievance related to call bell response that was discussed during Resident Council meetings for 5 consecutive months, May through September 2022. The findings included: A review of Resident Council (RC) meeting minutes revealed residents voiced a grievance related to poor call bell response in the May through September RC meetings. The following comments were made: ·May 25, 2022, 6 residents agreed that staff response to call lights took 20 minutes to an hour. ·June 15, 2022, 2 residents stated that staff's response to call lights was still an issue. ·July 20, 2022, 2 residents stated that there was	F 565	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. Affected Residents On 11/3/2022, the Assistant Administrator conducted a targeted call light response meeting with Resident #s 68, 92, 66, 17 and 40 from the Resident Council. The Assistant Administrator informed the group of measures to be taken to improve call light response on the 3:00 PM to 11:00 PM; 11:00 PM to 7:00 AM; and weekend shifts. Residents with potential to be affected All residents have the potential to be affected. On 11/3/2022, the Social	

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F 565	Continued From page 2 no change in staff's response to their call lights. ·August 17, 2022, 2 residents stated that they waited a long time for staff to respond to their call lights on the 11:00 PM - 7:00 AM shift. ·Sept 20, 2022, 2 residents stated they waited over 30 minutes to get their call light answered by staff. A RC meeting was held on 9/27/22 at 3:00 PM with 9 residents who were able to be interviewed. All 9 residents agreed that staff's response to their call lights had not improved, but had worsened, especially on the 3:00 PM to 11:00 PM, 11:00 PM to 7:00 AM shifts and weekends. The residents expressed this was an ongoing issue. During an interview on 9/26/22 at 1:51 PM with Resident #68, a RC member, she stated that it took a long time for staff to answer her call light. During an interview on 9/27/22 at 3:30 PM with Resident #92, a RC member, he stated, "I put on my light, if I fall asleep waiting for them, someone comes in and turns off my light, when I wake up, I have to put it on again." During an interview on 9/27/22 at 3:32 PM with Resident #66, a RC member, she stated staff took so long to answer the call light, staff would come turn off the light without giving you care and say they will come back but they don't. During an interview on 9/27/22 at 3:34 PM with Resident #17, a RC member, he stated staff took so long to answer the call light, they came in, turned off the light without giving you care and said they would be back, but they don't come back.	F 565	Worker (SW), Activities Director (Act. Dir.) and Activities Assistant (Act. Asst.) interviewed the remaining alert and oriented residents and family members of non-interviewable residents regarding call light response to determine if there were any other residents affected by the alleged deficient practice. The SW, Act. Dir and Act. Asst. informed those they spoke with of measures to be taken to improve call light response on the 3:00 PM to 11:00 PM; 11:00 PM to 7:00 AM; and weekend shifts. Systemic changes On 10/27/2022 the Staff Development Coordinator began educating all facility staff on call light response: " All facility staff are responsible for responding to call lights " Call lights should be responded to regardless of assignment. " Reset the call light once the call light has been responded to. " If need cannot be addressed immediately communicate a timeframe to the resident. The education will be completed by 11/9/2022. Any facility staff out on leave or PRN status will be educated by the SDC prior to returning to duty. All newly hired employees will be educated by the Human Resources Manager (HRC) or SDC during orientation. Monitoring: An audit tool that was developed to ensure compliance with the plan of correction. The audit includes the following:	

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F 565	Continued From page 3 During an interview and observation on 9/28/22 at 2:25 PM with Resident #40, a RC member, he stated staff come into his room, turn off his call light and don't come back to him. He further stated that his call light was on for 2 hours on Sunday, 9/25/22 before staff came in his room to answer it. A clock was observed on the wall in Resident #40's room. During an interview on 9/27/22 at 4:48 PM, the Activity Director (AD) stated she facilitated RC Meetings and during the last few meetings, residents expressed staff responded poorly to their call lights as a repeated concern. The AD stated she wrote down the residents' comments about call light response on a grievance form and gave it to the Social Worker (SW) to distribute to the appropriate department manager for follow up. The AD stated that because of this repeated concern, call light response was discussed during morning staff meetings, Quality Assurance & Performance Improvement meetings and staff received in-services which reminded all staff to answer call lights, but that residents continued to express that call light response was still an issue. The AD stated that in the September 2022 RC Meeting, residents said call bell response had not gotten better and stated their concerns were related to all shifts. During an interview on 9/27/22 at 5:19 PM, the Staff Development Coordinator (SDC) stated that she rounded periodically on all shifts to monitor staff's response to call lights, but that some residents had expressed to her that it was an ongoing concern that had not been resolved. The SDC stated that when residents voiced this concern to her, she notified the Director of	F 565	" Call lights answered timely: within 15 minutes. The audits will be completed for 5 residents daily on the 3:00 PM to 11:00 PM; 11:00 PM to 7:00 AM; and 5 residents daily on the weekend shifts. The Assistant Administrator will review the Special Ad hoc Resident Council minutes/feedback after each meeting to ensure residents have been informed of improvement measures and to implement modifications to the plan based on their feedback. QAPI The Assistant Administrator will bring the audits to the Quality Assurance and Performance Improvement Committee monthly for review and further recommendations to ensure compliance with the plan of correction. Completion Date is November 11, 2022	

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F 565	Continued From page 4	F 565		

Nursing (DON).

During an interview on 9/28/22 at 11:08 AM, the SW #1 stated that it was the responsibility of the SW to receive and coordinate a response to RC grievances by providing the grievances from RC Meetings to the appropriate department manager for follow up. SW #1 stated that until Thursday, 9/22/22 the facility had two SW and that her co-worker, SW #2 left employment on Thursday, 9/22/22. SW #1 stated that SW #2 was responsible for follow-up to RC grievances. SW #1 stated that during her rounds, residents made her aware that their call lights were not being answered. She stated that Resident #17 told her often that he did not feel his call light was answered timely. SW #1 stated that Resident #17 told her that he had to wait for staff to answer his call light and when they did answer it, staff turned his call light off without taking care of what he needed. SW #1 stated she shared the concern with call lights with the DON and during staff meetings.

SW #2 was unavailable for interview.

During an interview on 9/28/22 at 12:00 PM, the DON stated that she was aware that residents voiced concerns from the most recent RC Meetings regarding call bell response on 3:00 PM to 11:00 PM, 11:00 PM to 7:00 AM shifts. The DON stated that some residents had also voiced their concern with call light response directly to her. The DON stated that because of poor call light response voiced as a repeated resident concern, staff were re-educated in August 2022 and September 2022, the facility monitored for call bell response on the shifts residents expressed were concerns and planned to start a

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F 565	Continued From page 5 shift supervisor on 9/26/22 on the 3:00 PM to 11:00 PM shift, to assist with monitoring for call light response. The DON also stated that discussion occurred to re-implement a Manager on Duty (MOD) for weekends to provide monitoring during rounds. The DON stated that the MOD for weekends had not been implemented yet. The DON provided documentation of staff re-education dated 8/11/22, 8/25/22, 9/11/22, and 9/22/22 for review. During an interview with the Administrator on 9/28/22 at 1:49 PM, he stated that he was aware that residents expressed that staff's response to their call lights was an ongoing issue and had not been resolved. He stated that staff were re-educated in August 2022 and September 2022 and advised to respond to all call lights, how to respond, find out what the resident needed, set a timeline of when you can return to the resident if you can't address their concern right away and that he reiterated to the team that anybody can respond to the call lights. The Administrator stated that his team was aware that residents expressed improvement in call light response on day shift, but that the facility's greatest challenge was on the 2nd/3rd shifts and weekends where residents expressed call light response had not improved. He stated that Resident #17 and Resident #63 expressed concerns to staff regarding poor call light response on the weekends and that he planned to re-implement the MOD on weekends.	F 565		
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	F 656		11/11/22

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F 656	Continued From page 6	F 656		

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)-
(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.

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F 656	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop care plans for the use of an anticoagulant, use of an antianxiety, use of an antidepressant, use of an antipsychotic and the use of an opioid medications for 2 of 5 residents reviewed for unnecessary meds (Resident #14 and #33). The findings included: 1. Resident #14 was admitted on 05/02/22 with diagnoses that included atrial fibrillation. A review of Resident #14's physician orders revealed an order dated 06/16/22 for Eliquis (an anticoagulant) 2.5 milligrams (mg) by mouth twice a day for atrial fibrillation. Resident #14's care plan developed on 06/27/22 revealed there was no care plan developed for the use of the anticoagulant. An interview was conducted with the Minimum Data Set (MDS) Nurse on 09/28/22 at 12:10 PM. The Nurse explained that she developed care plan for high risk medications, and it was her normal routine to update the high-risk medication care plan when she completed the Resident's last MDS (06/27/22). The Nurse was asked to locate Resident #14's care plan for the Eliquis and the Nurse acknowledged that there was not a care plan developed for the medication. The Nurse explained that she must have overlooked the medication during her review and that a care plan should have been developed for the medication. On 09/29/22 at 2:11 PM an interview was	F 656	Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. Affected Residents: On 10/28/2022 the care plans for resident #14 was modified by the Minimum Data Set (MDS) Coordinator. Updates were made to accurately reflect the resident□s current medication regimen. The care plan dated 7/12/2022 for resident #33 reflected a care plan for high-risk medications associated with opioid analgesics, antianxiety and antipsychotics. No changes were required. Potentially Affected Residents: On 10/5/2022 and 10/28/2022, the MDS Coordinator and MDS Assistant audited all residents care plans currently in facility to ensure anticoagulants, antipsychotics, and narcotic analgesics since the last MDS assessment are accurate. No other residents were identified to lack care plans regarding opioid analgesics, antianxiety and antipsychotics. No resident was adversely affected by the alleged deficient practice. Measures/Systemic Changes: On 9/28/2022, the Assistant Administrator educated all Inter-disciplinary team (IDT)	

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F 656	Continued From page 8 conducted with the Director of Nursing (DON) who stated that it was her expectation that the high-risk medications were care planned. 2. Resident #33 was admitted on 03/13/20 with diagnoses that included anxiety, major depressive disorder, delusional disorder and insomnia. A review of Resident #33's physician orders revealed orders for Buspirone (an antianxiety) 15 mg by mouth three times a day dated 12/22/21, Hydrocodone-Acetaminophen (an analgesic, opioid) 5-325 mg by mouth one time a day as needed for pain dated 07/14/22, Risperidone (an antipsychotic) 0.5 mg by mouth once in the morning and 0.25 mg by mouth once at bedtime dated 02/11/22, and Trazadone (an antidepressant) 50 mg by mouth at bedtime dated 01/07/22. Resident #33's care plan developed on 07/11/22 revealed there was no care plan developed for the use of the high-risk medications Buspirone, Hydrocodone-Acetaminophen, Risperidone and Trazadone. An interview was conducted with the Minimum Data Set (MDS) Nurse on 09/28/22 at 12:10 PM who explained that it was her normal routine to update the Resident's care plan when she completed their last MDS (07/11/22). The Nurse was asked to locate Resident #33's care plan for the Buspirone, Hydrocodone-Acetaminophen, Risperidone and Trazadone and acknowledged there was no care plan developed for the high-risk medications. The Nurse explained that she must have overlooked the care plan during her review and that she should have developed a	F 656	members on accuracy of care plan. Education included; resident care plan must address the need for other important considerations such as pain management, antipsychotic medication, and anticoagulant medications. Care Plans must be reviewed and revised by the IDT/MDS coordinator(s) after each assessment, including both comprehensive and quarterlies. Monitoring: A monitoring tool was developed to monitor care plans for high-risk medications associated with opioid analgesics, antianxiety and antipsychotics. MDS Coordinator, MDS Assistant or Assistant Administrator will review all new admissions on an ongoing basis. MDS coordinator or designee will utilize monitoring tool and will audit new admissions weekly for 12 weeks. Continued audits will be determined based on results of prior 3 months of audits. Audit results will be presented by MDS Coordinator or designee monthly during QAPI meeting for a minimum of 12 weeks. Completion Date is November 11, 2022.	

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F 656	Continued From page 9 care plan for the use of the high-risk medications. On 09/29/22 at 2:11 PM an interview was conducted with the Director of Nursing (DON) who stated that it was her expectation that the high-risk medications be care planned.	F 656		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to label and date refrigerated items. The facility also failed to maintain a temperature of 41 degrees or below in a nourishment refrigerator. The findings included:	F 812	Residents affected: On 9/26/2022, the Dietary Manager immediately discarded the unlabeled food in the walk-in refrigerator in the kitchen. On 9/28/2022 the staff member removed her food from the 600 hall nourishment refrigerator. On 9/28/2022 the nurse discarded the juice containers and food	11/11/22

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F 812	Continued From page 10 1a. An observation during the kitchen tour with Dietary Managers (DM #1 & #2) of the walk-in refrigerator occurred on 9/26/22 at 11:20 AM. Three food items in local grocery store bags and to-go containers of food were unlabeled in the walk-in Resident refrigerator in the kitchen. DM #1 confirmed the items belonged to dietary staff. An interview on 9/26/22 at 11:25 AM with DM #1 revealed food belonging to staff that was also unlabeled and dated, did not belong in the Resident refrigerator. DM #1 subsequently discarded the food belonging to staff. DM #1 further revealed there were staff lounges within the facility that had refrigerators for storing their lunch. 1b. An observation of a Resident Nourishment Refrigerator located on 9/28/22 at 5:23 PM indicated an unlabeled/ undated blue food bag that contained a plate of food and other items. After an unnamed Med Tech walked throughout the unit and asked other staff about the unlabeled/ undated food bag in the Nourishment refrigerator, it was revealed the bag belonged to a staff member. The staff member removed her food from the Resident Nourishment Refrigerator. An interview on 9/28/22 at 5:35 PM with the Director of Nursing (DON) revealed food items belonging to staff, should be stored in staff refrigerators in staff lounges located throughout the facility, not in Resident Nourishment Refrigerators. 2. An observation on 9/28/22 at 5:17 PM of the Resident Nourishment Refrigerator on Hall 100 indicated the refrigerator door was open and contained several juice containers/food items	F 812	items from the 100-hall nourishment refrigerator and closed the refrigerator door. No resident was adversely affected by the alleged deficient practice. Systemic Changes: On 11/2/2022, Dietary Manager began educating all kitchen staff on procedures for properly storing, labeling, dating, and sealing foods, and monitoring refrigerator temperatures. On 11/2/2022, the Staff Development Coordinator began educating all other facility staff on properly storing, labeling, dating, and sealing foods to include where staff food should be stored. This will be completed by 11/9/2022. Any staff out on leave or PRN status will be educated by the Dietary Manager or SDC prior to returning to duty. Any newly hired staff will be educated during orientation by the SDC or Dietary Manager. In addition, the Dietary Manager and/or Assistant manager with do daily walk-throughs to ensure appropriate temperature; proper labeling, dating, and sealing of opened foods and it is free of non-resident food items. Monitoring: An audit tool was developed for ensuring daily monitoring of appropriate temperature; proper labeling, dating, and	

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	345013	A. BUILDING _____ B. WING _____	C 09/29/2022

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F 812	Continued From page 11 while the thermometer read 49 degrees (greater than 41 degrees). An interview with Nurse #1 revealed she was unaware the Nourishment Refrigerator had been left open and the temperature was 49 degrees. An interview with the Administrator on 9/29/22 at 2:00 PM indicated staff food should only be stored in staff breakroom refrigerators. The Administrator further indicated there was no policy about storing staff foods in Resident refrigerators. The Administrator stated he was unaware the Nourishment Refrigerator temperature on Hall 100 was left open and was 49 degrees.	F 812	sealing of opened foods and it is free of non-resident food items. Dietary Manager and/or Assistant manager with do daily walk-throughs to ensure appropriate temperature; proper labeling, dating, and sealing of opened foods and it is free of non-resident food items. The Administrator will monitor progress and compliance weekly x 12 weeks. The results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months by the Dietary Manager for compliance and recommendations. Completion Date is November 11, 2022	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure garbage was contained in a closed dumpster and maintain a clean grease trap free of buildup. This included 1of 2 dumpsters. The findings included: An observation on 9/26/22 at 11:48 AM of the outdoor grease trap while on kitchen tour revealed the entire lid, front, sides, and ground were soiled with thick black layers of grease	F 814	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected: On 9/28/2022, the Dietary Manager provided surface cleaning of the grease trap. On 10/25/2022 the Administrator	11/11/22

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F 814	Continued From page 12 build-up. Also, discarded food (lettuce and jalapenos) was observed between the outdoor trash dumpster and recycle dumpster. The Dietary Manager (DM #1) 11:53 AM indicated an outside company was responsible for maintaining the grease trap but dietary or the maintenance department would clean the outside if needed in between service visits. She further indicated the housekeeping department was responsible for cleaning up garbage around the dumpsters. An interview with the Maintenance Manager on 9/26/22 at 11:58 AM revealed an outside company makes quarterly visits to empty the grease trap. The Maintenance Manager further revealed they last serviced the grease trap on 7/18/22. A review of a receipt from the outside company that serviced the grease trap on 7/18/22 did not reveal the outside contents of the grease trap was cleaned/ serviced. Two attempts for phone interviews were made to the outside grease trap company on 9/26/22 and 9/28/22. Voice mail messages were left. A review of the Grease Trap Service Agreement renewal dated 9/26/22 indicated a one-year agreement expiring 9/26/22 for grease removal and grease trap service. An observation of the grease trap during a follow-up kitchen tour on 9/28/22 at 9:20 AM revealed the entire lid, front, sides, and ground remained soiled with thick black layers of grease build-up.	F 814	requested that the contract vendor replace the grease trap. One 9/26/2022 an environmental services worker placed the food debris observed on the ground inside the dumpster. No resident was adversely affected by the alleged deficient practice. Systemic Changes: On 11/2/2022, the Administrator educated the Dietary Manager, Maintenance Director and Environmental Services Manager on the responsibility for maintaining the grease trap and dumpster areas. In addition, the Administrator, Assistant Administrator, Dietary Manager and Environmental Services Manager will conduct Environmental Rounds at least weekly to include observations of the grease trap and areas around and including the dumpster are clean and free of debris. Monitoring: An audit tool was developed for ensuring weekly monitoring of the grease trap and areas around and including the dumpster are clean and free of debris. The Administrator, Assistant Administrator, Dietary Manager and Environmental Services Manager will conduct Environmental Rounds at least weekly to include observations of the grease trap and areas around and including the	

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F 814	Continued From page 13 A follow-up interview with the Maintenance Manager on 9/29/22 at 1:10 PM revealed the grease trap had not been replaced in 7 years and probably should have been replaced. An interview with the Administrator on 9/29/22 at 2:00 PM indicated the grease trap was last serviced in July 2022 and the service agreement expired on 7/1/2022. He further indicated he signed a new grease trap service agreement on 9/26/22. He expected the housekeeping department, dietary or maintenance department to collectively maintain the cleanliness around the outdoor trash dumpsters.	F 814	dumpster are clean and free of debris. The Administrator will monitor progress and compliance weekly x 12 weeks. The results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months by the Dietary Manager for compliance and recommendations. Completion Date is November 11, 2022	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/11/22

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F 842	Continued From page 14	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 15 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and record review, the facility failed to maintain an accurate medication administration record (MAR) for 1 of 1 sampled resident (Resident #16). Findings included: Resident #16 was readmitted to the facility on 9/23/22 after a hospitalization. Her diagnosis included chronic pain. There was a standing order for Tylenol. A review of the Resident's physician orders revealed there was no order for Tylenol. An Admission Minimum Data Set (MDS) assessment dated 9/28/22 indicated Resident #16 was cognitively intact. During a follow-up interview on 9/26/22 at 11:50 AM with Resident #16, she revealed the Unit Manager administered Tylenol around 11:30 AM on 9/26/22. A review of the Electronic Medical Record (EMR) revealed no entries that Tylenol, hydrocodone, or any pain medication was administered to Resident #16 on 9/26/22. An interview with the Director of Nursing (DON) on 9/28/22 at 5:40 PM revealed when a medication is administered, it should be documented on the MAR. The DON reviewed the MAR and further revealed there was no entry on	F 842	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Resident affected: On 9/28/2022 the unit manager updated the resident #16□s medical record to reflect the initiation of the standing order and administration of Tylenol for pain. Resident #16 did not have any adverse effects from the alleged deficient practice. Other residents with potential to be affected: On 11/3/2022, the Minimum Data Set Coordinators interviewed all interviewable residents to determine if they made a request for pain medication; whether they received the medication and whether it was documented. There were no additional residents identified. No additional resident was adversely affected by the alleged deficient practice. System changes: The Staff Development Coordinator (SDC) will educate all licensed nursing staff on proper procedures for documenting medications	

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F 842	Continued From page 16 the MAR that Resident #16 received pain medication on 9/26/22. An interview with the Unit Manager on 9/29/22 at 10:50 AM indicated she administered 650 mg of Tylenol (standing order) to Resident #16 on 9/26/22. She further indicated she became busy with other tasks during her shift and intended to submit a onetime order, then document she administered Tylenol to the Resident. She documented a one-time order on 9/28/22, after she was notified by the DON that she did not document administration of Tylenol to Resident #16 on 9/26/22. A follow-up interview with the DON on 9/29/22 at 2:43 PM revealed in her opinion if the Resident received Tylenol that was not documented on the MAR that it was given, she could have inadvertently received an additional dose that could cause adverse effects such as damage to her kidneys. Nurses are trained to document as they administer. An interview with the Administrator on 9/29/22 at 2:10 PM indicated medications that are administered to residents are expected to be documented in a timely manner. Therefore, medications administered on 9/26/22 should have been documented on the MAR on 9/26/22, not on 9/28/22.	F 842	administered to residents. This will be completed by 11/9/2022. Any licensed nursing staff out on leave or PRN status will be educated by the SDC prior to returning to duty. Any newly hired licensed nurses will be educated on this during orientation by the SDC. Monitoring: An audit tool was developed to ensure compliance with the plan of correction. The audits include interviewing 10 alert and oriented residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month to ensure that if a pain medication was administered, that it was documented in the medical record. Audits will be conducted by the SDC, DON, or their designee. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction. Completion date is November 11, 2022	