STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 9/13/22 through 9/16/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8NV911.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 9/13/22 through 9/16/22. Event ID# 8NV911. The following intakes were investigated: NC00188102, NC00189245, NC00189923, NC00191563, NC00191757, and NC00192012. Sixteen (16) of the 16 complaint allegations were not substantiated.	F 000		
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.	F 636		10/14/22

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

Electronically Signed | 10/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 1 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive 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.	F 636		

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F 636	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete admission Minimum Data Set (MDS) assessments for 2 residents within 14 days of admission/readmission (Resident #320 and Resident #68) and failed to complete an annual MDS assessment for 1 resident (Resident #38) within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 3 of 17 residents reviewed for MDS. Findings included: 1.Resident #320 was admitted to facility on 9/1/22. On 9/16/22 Resident #320 ' s admission MDS assessment with an ARD of 9/7/22 was observed as "in progress" and incomplete. An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated the admission MDS assessment dated 9/7/22 for Resident #320 was late and should have been completed no later than 9/14/22 and she was working on it. She explained that they have needed another MDS Nurse for several months and that was what caused the assessments to be behind. MDS Nurse#1 stated it was important to complete the required assessments timely. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.	F 636	This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 636] Comprehensive Assessments & Timing Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1. On 9/28/2022 Resident #-320's admission Minimum Data Set (MDS) was completed by the MDS coordinator. 2. On 9/22/2022 Resident 68's admission Minimum Data Set (MDS) was completed by the MDS coordinator. 3. On 10/07/2022 Resident #38's annual Minimum Data Set (MDS) assessment was completed by the MDS coordinator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The MDS coordinator and designee will audit all current admissions to ensure Minimum Data Set (MDS) assessments are complete, any found not completed will be completed by October 14, 2022.	

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F 636	Continued From page 3 2. Resident #68 was admitted to the facility on 8/17/22, discharged on 8/30/22 and reentered on 9/2/22. On 9/16/22 Resident #68 ' s admission MDS assessment with an ARD of 9/8/22 was observed as "in progress," and incomplete. An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated the admission MDS dated 9/8/22 for Resident #68 was late and should have been completed. She explained that they have needed another MDS Nurse for several months and that was what caused the assessments to be behind. The MDS Nurse stated it was important to complete the required assessments timely. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She indicated that it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware that there were assessments that were late. 3. Resident #38 was admitted on 6/2/15. On 9/16/22 Resident #38 ' s annual Minimum Data Set assessment with an ARD of 7/4/22 was observed as "in progress" and incomplete. An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated the admission MDS dated 9/8/22 for Resident #68 was late and should have been completed. She explained that they have needed another MDS Nurse for several	F 636	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Weekly audits x 4 weeks, then biweekly x 2 and monthly x 1 by MDS coordinator/designee of comprehensive assessments being completed timely. If issues are identified they will be corrected and additional education will be completed as necessary. The MDS coordinator/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 26, 2022 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 4 months and that was what caused the assessments to be behind. The MDS Nurse stated it was important to complete the required assessments timely. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She indicated that it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware that there were assessments that were late	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the required Significant Change in Status Assessments (SCSA) for 1 of 17 residents (#115) reviewed for assessments. The findings included: Resident #115 was admitted on 5/18/22 with	F 637	This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	10/14/22

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F 637	Continued From page 5 medical diagnoses which included in part multiple myeloma, muscle weakness, depression, and congestive heart failure. Review of Resident #115 ' s admission Minimum Data Set (MDS) assessment dated 5/24/22 revealed she was cognitively intact and required limited assistance with bed mobility. She was independent with eating, no weight loss was noted and had a current weight of 120 pounds (#). She was noted as occasionally incontinent of bladder and always continent of bowel. Care plans dated 5/27/22 noted a self-care deficit problem related to muscle weakness and unsteady gait. The goal indicated Resident #115 would show an increase in functional ADL ' s, improve balance and independence with ADL ' s. Approaches included assist with transfers, toileting, bathing and hygiene and physical and occupational therapy evaluation and treatment. Nutritional status was also addressed in the care plan with a goal: Will show no significant weight change thru next review. There was no indication that the care plan was updated and revised. Review of Resident #115 ' s 6/16/22 physical therapy discharge summary revealed she was independent with bed mobility. Review of Resident #115 ' s medical record revealed resident ' s weights were: 6/17/22-94#, 6/24/22-91#, 6/27/22-89#, 6/29/22- 86#. A progress note dated 6/28/22 indicated Resident #115 was experiencing periods of confusion and was incontinent of bowel and bladder. A physician order was dated 6/28/22 for comfort	F 637	[F 637] Comprehensive Assessment After Significant Change Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1. Resident #115 expired on 7/16/2022 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The MDS coordinator and designee will audit all current admissions to ensure significant change in status assessments are complete, any found not completed will be completed by October 14, 2022. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Weekly audits x 4 weeks, then biweekly x 2 and monthly x 1 by MDS coordinator/designee of comprehensive assessments after significant change being completed timely. If issues are identified they will be corrected and additional education will be completed as necessary. The MDS coordinator/designee will be responsible to ensure implementation of the acceptable plan of correction	

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F 637	Continued From page 6 care due to Resident #115 ' s decline in condition and a desire for no aggressive measures. A nursingt progress note on 7/11/22 indicated resident #115 had severe decline, was refusing medications, fluid, and food, had a change in cognition and was unable to reposition herself in bed. A death in facility MDS tracker dated 7/16/22 was observed in the record. No other MDS assessments were observed in Resident #115 ' s record. An interview with MDS Nurse #1 on 9/16/22 at 1:30 PM revealed that she was aware of the indications of when a Significant Change in Status (SCSA) MDS assessment should be completed. She stated that the SCSA should have been completed for Resident #115 when her condition declined. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She indicated that it was her expectation that all MDS assessments were completed accurately and timely.	F 637	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 26, 2022 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 638 SS=E	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	F 638	This plan of correction constitutes my	10/14/22

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F 638	Continued From page 7 facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 12 of 40 residents reviewed for MDS (Residents #2, #19, #29, #77, #72, #40, #20, #28, #16, #47, #164 and #32). Findings included: 1. Resident #2 was admitted to facility on 3/23/22. On 9/15/22 Resident #2 ' s quarterly minimum data set (MDS) assessment with an ARD of 6/28/22 was observed as "open" and incomplete. An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late. 2. Resident #19 was admitted to the facility on 11/29/21. On 9/15/22 Resident #19 ' s quarterly MDS assessment with an ARD of 7/1/22 was observed as "in progress" and incomplete. An interview was conducted on 9/16/22 at 1:30	F 638	written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 638] Quarterly Assessment at Least Every 3 Months Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1. Resident #2 quarterly assessment will be completed by 10/7/2022 2. Resident #19 quarterly assessment was completed on 9/16/2022 3. Resident #29 quarterly assessment will be completed by 10/07/2022 4. Resident #77 quarterly assessment will be completed by 10/07/2022 5. Resident #72 quarterly assessment will be completed by 10/07/2022 6. Resident #40 quarterly assessment will be completed by 10/07/2022 7. Resident #20 quarterly assessment was completed on 9/28/2022 8. Resident #28 quarterly assessment was completed on 9/15/2022 9. Resident #16 quarterly assessment will be completed by 10/07/2022 10. Resident #47 quarterly assessment was completed on 10/4/2022 11. Resident #164 quarterly assessment was completed on 9/15/2022	

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F 638	Continued From page 8 PM with MDS Nurse #1 who stated when an MDS was listed as "in progress" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late. 3.Resident #29 was admitted to the facility on 12/6/19. On 9/15/22 Resident #29 ' s quarterly MDS assessment with an ARD of 8/2/22 was observed as "in progress" and incomplete. An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "in progress" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up. An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late. 4. Resident # 77 was admitted to the facility on	F 638	12. Resident #32 quarterly assessment was completed on 9/16/2022 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The MDS coordinator and designee will audit all current admissions to ensure quarterly assessments are complete, any found not completed will be completed by October 14, 2022. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Weekly audits x 4 weeks, then biweekly x 2 and monthly x 1 by MDS coordinator/designee of quarterly assessments being completed timely. If issues are identified they will be corrected and additional education will be completed as necessary. The MDS coordinator/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 26, 2022 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 638	Continued From page 9	F 638		

1/11/22.

On 9/15/22 Resident #77 ' s quarterly MDS assessment with an ARD of 7/11/22 was observed as "open" and incomplete.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

5. Resident #72 was admitted to the facility on 3/29/18.

On 9/15/22 Resident #72 ' s quarterly MDS assessment with an ARD of 6/29/22 was observed as "open" and incomplete.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated

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F 638	Continued From page 10	F 638		

it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

6. Resident #40 was admitted to the facility on 10/14/14.

On 9/15/22 Resident #40 ' s quarterly MDS with an ARD of 8/5/22 was observed as "open" and incomplete.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

7.Resident #20 was admitted to the facility on 1/22/18.
On 9/15/22 Resident #20 ' s quarterly MDS with an ARD of 7/5/22 was observed as "open" and incomplete.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS

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F 638	Continued From page 11	F 638		

assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

8. Resident # 28 was admitted to the facility on 5/24/22.

On 9/15/22 Resident #28 ' s quarterly MDS assessment with an ARD of 8/26/22 was observed as completed on 9/15/22.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who explained the quarterly MDS assessment was completed late.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

9. Resident #16 was admitted to the facility on 6/5/18.

On 9/15/22 Resident #16 ' s quarterly MDS assessment with an ARD of 6/29/22 was observed as "in progress" and incomplete.

An interview was conducted on 9/16/22 at 1:30

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F 638	Continued From page 12	F 638		

PM with MDS Nurse #1 who stated when an MDS was listed as "in progress" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

10. Resident # 47 was admitted to the facility on 10/29/18.

On 9/15/22 Resident #47 ' s quarterly MDS assessment with an ARD of 6/15/22 was listed as "open" and incomplete.

An interview was conducted on 9/16/22 at 1:30 PM with MDS Nurse #1 who stated when an MDS was listed as "open" it was not completed. MDS Nurse #1 explained the quarterly MDS assessment was late, she was aware of the completion date and was working on getting caught up.

An interview was conducted with the Administrator on 9/16/22 at 4:24 PM. She stated it was her expectation that all MDS assessments were completed on time. The Administrator revealed it had been a challenge to keep MDS assessments up to date and she was aware there were assessments that were late.

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F 638	Continued From page 13	F 638		

11. Resident #164 was admitted to the facility from a hospital on 5/5/21. His cumulative diagnoses included Parkinson ' s disease.

Review of the resident ' s Minimum Data Set (MDS) assessments revealed an annual MDS had an Assessment Reference Date (ARD) of 4/29/22. Resident #164 ' s most recent MDS was a quarterly assessment with an ARD of 7/25/22. The quarterly MDS dated 7/25/22 was still "open" on the date of the review (9/14/22) and was not signed or dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed.

An interview was conducted on 9/15/22 at 10:40 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses reviewed Resident #164 ' s quarterly MDS dated 7/25/22 and confirmed it was still "open." Upon further inquiry, MDS Nurse #1 confirmed this assessment was past the required time frame for completion. During the onsite visit, MDS Nurse #1 reported they had a plan and were working towards a goal to catch up on the MDS assessments. The nurses did not provide any additional information and when asked, the nurses did not share the anticipated date of completion for this plan. After the survey, a partial plan of correction was received that did not include identified residents or a completion date.

An interview was conducted on 9/15/22 at 11:25 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect MDS assessments to be completed in a

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F 638	Continued From page 14 timely manner. 12. Resident #32 was admitted to the facility from a hospital on 5/25/22. Her cumulative diagnoses included non-traumatic brain dysfunction. Review of the resident ' s Minimum Data Set (MDS) assessments revealed an admission MDS had an Assessment Reference Date (ARD) of 5/31/22. Resident #32 ' s most recent MDS was a quarterly assessment with an ARD of 8/4/22. The quarterly MDS dated 8/4/22 was still "open" on the date of the review (9/15/22) and was not signed or dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed. An interview was conducted on 9/15/22 at 10:40 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses reviewed Resident #32 ' s quarterly MDS dated 8/4/22 and confirmed it was still "open" and past due. During the onsite visit, MDS Nurse #1 reported they had a plan and were working towards a goal to catch up on the MDS assessments. The nurses did not provide any additional information and when asked, the nurses did not share the anticipated date of completion for this plan. After the survey, a partial plan of correction was received that did not include identified residents or a completion date. An interview was conducted on 9/15/22 at 11:25 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect MDS assessments to be completed in a timely manner.	F 638		
F 655 SS=D	Baseline Care Plan	F 655		10/14/22

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F 655	Continued From page 15 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 16 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a resident centered baseline care plan to address dementia, mobility needs and falls (Resident #320 and Resident #319) on admission for 2 of 17 residents reviewed for baseline care plans. The findings included: 1. Resident #320 was admitted to the facility on 9/1/22 with diagnoses that included in part lymphedema, weakness, cognitive communication deficit, Alzheimer ' s disease, and dementia. Review of Resident #320 ' s 9/1/22 physical therapy evaluation revealed resident presented with weakness, confusion with cognitive challenges, severe lower extremity swelling with impaired ability to stand and transfer. Physical therapy recommended the use of a gerichair (reclined lounge chair with elevated footrests) for safety. Review of Resident #320 ' s baseline care plan dated 9/2/22 did not include information about his impaired cognition or the recommended use of a gerichair. An interview conducted with the Nursing Supervisor on 9/15/22 at 4:12 PM revealed Resident #320 had dementia, required a gerichair	F 655	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 655] Baseline Care Plans Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/16/2022 Resident #320’s baseline care plan was updated by the DON to include goals and interventions related to Resident #320’s information about his impaired cognition and recommended use of the gerichair. This information been included in Resident #320’s medical record. The baseline care plan was then reviewed with the family by the DON on 9/16/2022. On 9/16/2022, Resident #319’s baseline care plans was updated incorporating information that was in the record related to Resident #319’s dementia, impaired	

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F 655	Continued From page 17 and frequent monitoring due to high fall risk. An interview on 9/16/22 at 12:26 PM with MDS Nurse #1 revealed that the baseline care plan was initiated by the nurse on the floor within the first couple of days after admission. MDS Nurse #1 stated that she looked over the baseline care plans and updated them as needed. She further indicated that dementia, impaired cognition, falls interventions and use of gerichair should be included in the baseline care plan which is to be developed 48 hours after admission. An interview at 4:24 PM on 9/16/22 with the Administrator revealed that the baseline care plans should be developed within 48 hours, should be person centered and include areas such as falls interventions, equipment needed and dementia that are significant to each resident ' s care. 2. Resident #319 was admitted to the facility on 9/9/22. Resident #319 ' s medical diagnoses included in part hip fracture, rib fracture, history of falls, dementia, and history of brain hemorrhage. Review of Resident #319 ' s physical therapy evaluation dated 9/9/22 revealed he was a high fall risk with a recent fall with hip and rib fractures and had difficulty with bed mobility and transfers. Review of Resident #319 ' s baseline care plan dated 9/9/22 revealed the following interventions for falls/safety: evaluate cognitive status and gait steadiness, proper footwear, and ambulation device, maintain safe environment, and wander risk assessment.	F 655	cognition, falls intervention and use of a gerichair. The baseline care plan for Resident #319 was reviewed with family by the DON on 9/16/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 10/5/2022, the DON's designee audited all Resident charts to ensure baseline care plans that addressed goals and intervention had been completed within 48 hours of admission. Any charts found to not have a baseline care plan in place or which had baseline care plans that did not include goals and intervention were corrected and resident/family notified by DON/designee. All Nurses will be educated by DON/designee as to proper procedure and implementation of baseline care plan reviews, and to ensure that goals and interventions for treatment of Residents are included in baseline care plan. The in-service will be completed by 10/14/22. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Random audits of baseline care plans will be performed by DON/designee weekly x 4 weeks, then bi-weekly x 2, and monthly x 1 to ensure policy and procedures are followed relating to the implementation of baseline care plans, including the inclusion of goals and interventions.	

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F 655	Continued From page 18 An observation of Resident #319 on 9/13/22 at 12:41 PM revealed resident was sitting on the edge of the bed, which was in a high position, when he suddenly got up unassisted and fell to the floor hitting his head. Fall mats were observed on the floor on the far side of the bed. Staff assessed Resident #319 for injury, assisted him in to a gerichair (reclined lounge chair with elevated footrests) and brought him to the common area for observation. An interview conducted with the nursing supervisor on 9/15/22 at 4:12 PM revealed Resident #319 was a high fall risk, should have his bed in low position, a gerichair was being used for safety and he was to be monitored frequently to prevent falls. An interview on 9/16/22 at 12:26 PM with MDS Nurse #1 revealed that the baseline care plan was initiated by the nurse on the floor within the first couple of days after admission. MDS Nurse #1 stated that she looked over the baseline care plans and updated them as needed. She further indicated that dementia, impaired cognition, falls interventions and use of gerichair should be included in the baseline care plan which is to be developed 48 hours after admission. An interview at 4:24 PM on 9/16/22 with the Administrator revealed that the baseline care plans should be developed within 48 hours, should be person centered and include areas such as falls interventions, equipment needed and dementia that are significant to each resident ' s care.	F 655	Baseline care plans are to be completed within 48 hours of admission and a copy will be reviewed with resident/family and review documented appropriately. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 26, 2022 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		10/14/22

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F 758	Continued From page 19 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 20 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the timeframe for a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) ordered to be given on an as needed (PRN) basis for 2 of 2 residents reviewed who received a PRN psychotropic medication (Resident #32 and Resident #115). The findings included: 1. Resident #32 was admitted to the facility on 5/25/22. Her cumulative diagnoses included non-traumatic brain dysfunction. The resident ' s most recent completed Minimum Data Set (MDS) assessment was an admission assessment dated 5/31/22. At that time, Resident #32 was assessed to have intact cognitive skills for daily decision making. This MDS assessment indicated the resident received an antianxiety medication on 5 out of 7 days during the look back period. Resident #32 ' s paper medical record included physician ' s orders dated 8/22/22 for the resident	F 758	This plan of correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 758] Free from Unnec Psychotropic Meds/PRN Use Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #32’s medications were reviewed and evaluated by physician on 9/05/22 to ensure Resident #32 was receiving appropriate medication and necessary documentation was included. An order was entered by physician that specified the rationale for extending the previously prescribed psychotropic drug prn administration past 14 days. Resident #32, with orders for comfort care, had	

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F 758	Continued From page 21 to receive comfort care. An order was also received on 8/22/22 to initiate 0.5 milligrams (mg) lorazepam (an antianxiety medication, which is also a controlled medication) to be given by mouth every 4 hours as needed (PRN) for agitation. A review of the resident ' s electronic medical record (EMR) revealed the order for 0.5 mg lorazepam to be given as one tablet by mouth every 4 hours as needed was input into the computer system on 8/22/22. This order was discontinued on 8/23/22 with a new order put into the computer that read: "Ativan (lorazepam) 0.5 mg tablet. Take one tablet by mouth every 4 hours as needed. Order Date: 8/23/22; Start Date: 8/23/22." No stop or discontinue date was included in the resident ' s EMR orders or on the resident ' s August 2022 Medication Administration Record (MAR). Resident #32 ' s Controlled Medication Utilization Record (a declining inventory record) for 0.5 mg lorazepam documented one dose of lorazepam was taken from the inventory and administered to the resident on each of the following dates/times: 8/24/22 at 6:30 PM, 8/25/22 at 1:00 AM, 8/26/22 at 6:30 PM, 8/27/22 at 9:00 PM, 8/29/22 at 12:00 PM and 8/29/22 at 4:00 PM. Resident #32 ' s physician ' s orders in the EMR and the orders on the September 2022 MAR continued to read: "Ativan (lorazepam) 0.5 mg tablet. Take one tablet by mouth every 4 hours as needed. Order Date: 8/23/22; Start Date: 8/23/22." No stop or discontinue date was included with the order. The resident ' s Controlled Medication Utilization	F 758	been seen repeatedly in the past by physician services for evaluation of behaviors relating to diagnosis. The physician reviewed, on 09/05/2022 the need for extension of PRN order and extended order with a 30 day stop date. Resident # 115 expired on July 16, 2022 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The DON will audit current orders for any resident found to be on PRN psychotropic medications to ensure documentation of rationale and duration to extend as needed. Residents with order for psychotropic meds will have orders evaluated by physician/NP to ensure a stop date or rationale for extending the duration of the PRN medication. The DON/designee will communicate and document her communication with physician(s) to ensure compliance. The DON/designee will round with physician weekly, for 4 weeks, to ensure physician reviews of communication and that psychotropic PRN medications have a stop date or rationale for extending the duration of the PRN medication past 14 days. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Weekly audits x 4 weeks, then biweekly x	

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F 758	Continued From page 22 Record for 0.5 mg lorazepam documented one dose of lorazepam was taken from the inventory and administered to Resident #32 on each of the following dates/times: 9/2/22 at 6:00 PM, 9/3/22 at 6:00 PM, 9/7/22 at 7:00 PM, 9/9/22 at 7:00 PM, and 9/12/22 at 7:00 PM. An interview was conducted on 9/16/22 at 10:40 AM with Nurse #1. During the interview, Nurse #1 confirmed she had input the order for Resident #32's PRN lorazepam into the computer. Upon inquiry, the nurse stated she did not know that an order for PRN lorazepam required a stop date even if a resident was on comfort care. A follow-up interview was conducted upon Nurse #1 ' s request on 9/16/22 at 11:45 AM. The nurse reported after talking about Resident #32's PRN lorazepam, she recalled having consulted with the Nurse Supervisor about the order. She reported the Nurse Supervisor was going to check with the Medical Doctor (MD) about the order. Nurse #1 stated at the time she put the order for PRN lorazepam into the computer, she did not have a stop date. The nurse reported she just found documentation in the medical records for clarification of Resident #32 ' s PRN lorazepam order. An M.D. (Medical Doctor) Fax Order Sheet signed and dated 9/5/22 included a hand-written notation which read, "Please continue Ativan (lorazepam) 0.5 mg po (by mouth) q (every) 4 hours prn agitation x (for) 30 days." When asked, Nurse #1 confirmed a stop date for the PRN lorazepam was not in the computer system at the time of the review on 9/16/22. An interview was conducted on 9/16/22 at 12:15 PM with the Nurse Supervisor. The Nurse Supervisor recalled the time when Nurse #1 discussed Resident #32 ' s PRN lorazepam order	F 758	2 and monthly x 1 by DON/designee of orders for psychotropic med use will be conducted to ensure compliance with regulation. Facility DON /designee will monitor physician communication weekly x four weeks to ensure pharmacists and physician communication are being delivered and responded to as appropriate. If issues are identified they will be corrected and additional education will be completed as necessary. The DON/designee will be responsible to ensure implementation of the acceptable plan of correction Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting October 26, 2022 and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 758	Continued From page 23	F 758		

with her. The Supervisor reported she caught the resident ' s MD while he was in the building to complete the information for the lorazepam order on an M.D. Fax Order Sheet. The Supervisor stated she asked the MD, "Can we extend it?" She noted his response on the form but couldn't input it into the computer because her computer was down at the time. Upon further inquiry as to what she meant by extending the lorazepam order, the Supervisor stated she was not aware that no stop date had been put in with the initial order and thought Nurse #1 was asking if the stop date for this medication could be extended past 14 days since Resident #32 was now on comfort care. When asked, the Supervisor reiterated she thought the nurse had put in a 14-day stop date for the PRN lorazepam ordered.

An interview was conducted with the facility's consultant pharmacist on 9/16/22 at 8:40 AM. During the interview, concern with regards to Resident #32 ' s PRN lorazepam being ordered without a stop date was discussed. The pharmacist reported she would expect an order written for PRN lorazepam to have a stop date included in the order. She reported her September visit to conduct a monthly medication regimen review for Resident #32 wasn ' t due so she had not yet had an opportunity to review this order.

An interview was conducted on 9/16/22 at 10:30 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she talked with the nurse who input the order for PRN lorazepam without a stop date and did re-educate her. The DON reported she would have expected this initial PRN lorazepam order to be put into the computer with a stop date of 14 days even

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F 758	Continued From page 24 though the resident was on comfort care measures. 2. Resident # 115 was admitted to the facility on 5/18/22. Resident #115 was placed on comfort care on 6/28/22. Resident #115 ' s 5/24/22 admission Minimum Data Set (MDS) assessment revealed the resident was cognitively intact and had no behaviors. Resident #115 received a psychotropic medication, antidepressant, 6 out of 7 days during the 7-day assessment look back period. Resident #115 ' s paper medical record revealed a physician order written on 6/28/22 for lorazepam a psychotropic medication classified as an antianxiety medication) 2 grams per milliliter administer 0.25 milliliters every 4 hours as needed for anxiety with no stop date indicated. Review of Resident #115 ' s paper medication administration record (MAR) for July 2022 revealed the resident received as needed doses of lorazepam on 7/6/22, 7/7/22, 7/8/22 and 7/16/22. An interview on 9/16/22 at 8:45 AM was conducted with the facility ' s consultant pharmacist. The pharmacist reported that she would expect an order written as needed for lorazepam to include a stop date not to exceed 14 days. An interview on 9/16/22 at 10:30 AM with the facility ' s Director of Nursing (DON) revealed that she would expect a PRN (as needed) order for lorazepam would include a stop date of 14 days.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		10/14/22

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F 761	Continued From page 25 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) Label an opened, injectable medication with the minimum information required (including the name of the resident) stored in 1 of 2 medication storage rooms observed (Pinehurst Med Room); 2) Label medications with the date they were opened to allow the shortened expiration date to be determined in 2 of 2 medication storage rooms observed (Pinehurst Med Room and Triangle	F 761	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 761	Continued From page 26 Med Room); 3) Discard expired medications stored in 1 of 2 medication storage rooms observed (Pinehurst Med Room); and 4) Store a medication in accordance with the manufacturer ' s storage instructions in 1 of 2 medication storage rooms observed (Triangle Med Room). The findings included: 1. An observation was conducted on 9/14/22 at 4:00 PM of the Pinehurst Medication Storage Room in the presence of Nurse #3. The observation revealed one - 10 milliliter (ml) opened vial of 70/30 Novolin insulin was stored in the manufacturer box in the refrigerator. Neither the vial of insulin nor the manufacturer box were labeled with a resident's name. Both the vial and the box had a hand-written date on them to indicate the vial was opened on 5/2/22. The manufacturer box also had a hand-written notation on it which read, "expired 5/30." Upon request, Nurse #3 confirmed that neither the insulin vial nor the box were labeled with a resident ' s name. She also acknowledged the insulin was expired at the time of the observation on 9/14/22. An interview was conducted on 9/15/22 at 11:08 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect a vial of insulin to be labeled with a resident ' s name if it had been pulled from the house stock. If the label had come off, she would expect the nursing staff to discard the vial of insulin and reorder it for the resident. Expired insulin needed to be discarded.	F 761	[F 761] Label/Store Drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1. On 9/14/22 the Novolin insulin that was found in the Pinehurst Medroom refrigerator was discarded. 2. A. On 9/14/22 the two opened multi-dose vials of Tuberlin PPD injectable medication found in the Pinehurst Medroom refrigerator were discarded. 3. On 9/14/22 the opened multi-dose vial of Tuberculin PPD injectable found in the Triangle Medroom refrigerator was discarded. 4. On 9/14/22 the mouthwash in the Pinehurst Medroom refrigerator belonging to resident #121, who had discharged from the facility, was discarded. 5. On 9/14/22 the two bottles of famotidine in the Triangle Medroom refrigerator were discarded. Famotidine for Resident #120 was re-ordered with our pharmacy, the new bottles are stored at the proper temperature range, 77-86 F Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 9/15/2022 the DON/designee observed medication rooms on Pinehurst and Triangle Gardens and confirmed all insulins and tuberculin were dated appropriately and no issues identified with storage or labeling, the DON/designee also confirmed that there were no other	

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F 761	Continued From page 27 2-a. An observation was conducted on 9/14/22 at 4:00 PM of the Pinehurst Medication Storage Room in the presence of Nurse #3. The observation revealed two opened multi-dose vials of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) were stored in the med room refrigerator. Neither the vials nor the manufacturer boxes they were stored in were labeled as to when the vials had been opened. Upon request, Nurse #3 examined the vials and manufacturer boxes. The nurse confirmed no date was written on the vials or boxes to indicate when they had been opened. Nurse #3 reported she would discard the vials of the Tuberculin PPD injectable medication due to not knowing when the vials had been opened. The manufacturer's storage instructions and labeling on the box for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days. An interview was conducted on 9/15/22 at 11:08 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect nursing staff to write the date opened and expiration date on both the vial and box of Tuberculin PPD as soon as the seal for the injectable medication was broken. 2-b. An observation was conducted on 9/14/22 at 3:47 PM of the Triangle Medication Storage Room in the presence of Nurse #2. The observation revealed one opened multi-dose	F 761	opened and unmarked medicine . All nurses in-serviced by the DON/designee on proper storage and labeling of insulin, tuberculin and famotidine. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Random audits of med rooms for proper storage and labeling of insulin, tuberculin and proper storage of famotidine for resident #120 will be conducted by the nurse supervisors/designee for a period of weekly x 4 weeks, bi-weekly x 2 months, to ensure there is no expired/unlabeled medication in the med room and medication is stored properly. The DON/designee will be responsible for implementing the acceptable plan of correction. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	

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F 761	Continued From page 28	F 761		

vials of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in was labeled as to when the vial had been opened. Upon request, Nurse #2 examined the vial and manufacturer box. The nurse confirmed no date was written on the vial or box to indicate when it had been opened. Nurse #2 stated, "I can discard that one."

The manufacturer's storage instructions and labeling on the box for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days.

An interview was conducted on 9/15/22 at 11:08 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect nursing staff to write the date opened and expiration date on both the vial and box of Tuberculin PPD as soon as the seal for the injectable medication was broken.

3. An observation was conducted on 9/14/22 at 4:00 PM of the Pinehurst Medication Storage Room in the presence of Nurse #3.

The observation revealed one bottle of R-Duke ' s Magic Mouthwash (a compounded medication) with approximately 250 milliliters (ml) remaining in the bottle was stored in the refrigerator. This medication was labeled as having been dispensed from the pharmacy for Resident #121 on 6/25/22. The expiration date written on the label was 7/8/22. Upon request, Nurse #3 examined the medication bottle and confirmed

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F 761	Continued From page 29	F 761		

the mouthwash was expired.

An interview was conducted on 9/15/22 at 11:08 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect expired medications to be discarded.

4. An observation was conducted on 9/14/22 at 3:47 PM of the Triangle Medication Storage Room in the presence of Nurse #2.

The medication room refrigerator temperature was confirmed by Nurse #2 to be 41 degrees (o) Fahrenheit (F). The observation of the med room refrigerator revealed two bottles of 40 milligrams (mg) / 5 milliliters (ml) famotidine for oral suspension (a medication used to treat gastroesophageal reflux disease) dispensed by pharmacy for Resident #120 on 9/13/22 was stored in the med room refrigerator. Both bottles were reconstituted.

The medication ' s package insert was included in a plastic bag with the two bottles of the famotidine suspension. The package insert provided storage instructions which indicated both the dry powder and a reconstituted suspension should be stored at 25o Celsius (C) or 77 o F with excursions permitted to 15 - 30o C or 59 - 86 o F.

A review of Resident #120 ' s electronic medical record revealed he had a current order for 40 mg/5ml famotidine oral suspension to be given as 2.5 ml orally twice daily for gastroesophageal reflux disease.

An interview was conducted on 9/15/22 at 11:08

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F 761	Continued From page 30 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON reported she would have expected the famotidine oral suspension to have been stored on the medication cart (not in the refrigerator).	F 761		
F 812 SS=E	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 observation and staff interviews, the facility failed to label and date leftover food items in two of three nourishment refrigerators (100 hall and 200 hall) and failed to store perishable items in one of three nourishment rooms located on the 300 hall. The facility also failed to allow cups and dessert bowls to air dry prior to assemblage and stacking for two of two observations. These	F 812	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	10/14/22

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F 812	Continued From page 31 practices had the potential to affect residents. Findings Included: 1. An observation of the nourishment room on the 200 hall was conducted on 9/13/22 at 3:46 PM, and the refrigerator/freezer were inspected. The following items were found inside the freezer without a date or label: one open half gallon vanilla ice cream container, one open half gallon strawberry ice cream container, one open container of rainbow sherbet, and a half full chocolate milkshake in a fast-food cup with lid. An observation of the 300 hall nourishment room on 9/13/22 at 3:49 PM was conducted. On either side of the sink, the following perishable items were found on the counter: half eaten delivery food order in a plastic bag to the left of the sink with a receipt dated 9/13/22 at 9:21 AM, one opened half full fruit juice can in front of the condiment shelves, and two unopened yogurts in a plastic bag warm to the touch on the right side of the sink beside the microwave. During an interview with Nurse #1 on 9/13/22 at 3:52 PM, she revealed the dietary department and nursing staff managed the 300 hall nourishment room. She stated she was not sure why the leftover food and opened can of juice was on top of the counter. Nurse #1 indicated those items should have been discarded. An observation of the 200 hall nourishment room and interview were conducted with the Certified Dietary Manager (CDM) on 9/13/22 at 3:57 PM. She confirmed the two ice cream containers, one sherbet container, and fast-food cup did not have a label or date recorded. The CDM indicated all	F 812	federal law. [F 812] It is the policy of Hillcrest Raleigh at Crabtree (Hillcrest) to comply with the food procurement and sanitation guidelines as outlined in F812 and the FDA Food Code and the North Carolina Health Department. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1. The Dietary manager conducted a thorough inspection of nourishment rooms. The ½ gallon vanilla ice cream container was discarded along with the strawberry ice cream, container of rainbow sherbet and chocolate milkshake that was found on 200 hall. The food items found in the nourishment room on 300 halls were also discarded, delivery food, half full fruit juice and two yogurts. 2. All cups were removed from service and rewashed. Items were removed from their location near the steam table which caused condensation vs wet nesting. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The Dietary manager conducted a thorough survey of the nourishment rooms and kitchen immediately following the survey and there were no other concerns noted. The dietary manager/designee will in-service all	

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F 812	Continued From page 32 items should have been discarded. She then removed all items from the freezer and placed them in the trash can. An observation of the 300 hall nourishment and interview with the CDM were conducted on 9/13/22 at 4:00 PM. She revealed the two yogurt containers were not from kitchen and did not have a date, so she discarded them. The leftover meal and juice can were no longer on the counter. The CDM was notified those items were in the trash can, and she stated they belonged to staff. She further stated that she usually performed sweeps of the nourishment rooms in the afternoons. An interview with the CDM and observation of the 100 hall nourishment room on 9/13/22 at 4:03 PM were conducted. The CDM stated she had already swept/checked this area. A frozen meal that contained two separate portions with one portion removed did not have a label or date on it. The CDM discarded the item. The CDM stated nourishment rooms are for resident food items only and the frozen meal should have been labeled and dated. The Administrator was interviewed on 9/16/22 at 1:56 PM. She stated nourishment rooms were used by families. Staff monitored them multiple times throughout day. The Administrator indicated staff could check on the nourishment rooms one minute and then a family could have brought in a milkshake to store. She stated the facility had an outside food policy, and labels and markers were included in those rooms, along with a poster instructed to label/date the food. The Administrator indicated not all families complied with the policy. Personal refrigerators were not	F 812	dietary staff on proper food storage and labeling as well as wet nesting and location of items near the steam tables that may cause condensation on serving dishes. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; Weekly, unannounced inspections by the Registered Dietitian or her designee are taking place using an existing, but revised Hazard Surveillance form. The goal of this exercise is to continue a weekly inspection until three consecutive inspections indicate no issues of concern and then to maintain this process on a monthly unannounced basis. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and the dates are subject to the vote of this interdisciplinary committee.	

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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
F 812	Continued From page 33	F 812		

allowed in resident rooms due to safety hazards, and she tried to make the facility a homelike environment.

2. An observation of the kitchen and interview with the CDM were conducted on 9/13/22 at 10:49 AM. Nine plastic cups were observed to be stacked wet and ready for use on the beverage cart in front of the tray line. The CDM stated her expectation was that all dishware was to be air dried before use. She then removed all the juice cups to be rewashed. At 10:52 AM, six additional plastic cups were found with wet nesting at another beverage cart. The CDM indicated that she was training a new employee working in the dish area that had started last week.

An observation of the kitchen and interview with the CDM were conducted on 9/15/22 at 8:38 AM. On a cart to the left of the steam table, six plastic dessert containers and one ceramic dessert bowl were observed to have displayed wet nesting. The CDM indicated these items were ready to use.

During a follow-up interview with the CDM on 9/16/22 at 2:50 PM, the CDM revealed the ceramic and plastic dessert containers were wet due to the condensation from the steam table. She indicated that she had witnessed during dinner meal on 9/15/22 that the dishes near the steam table developed condensation. Therefore, dishes will no longer be placed in that area to prevent development of condensation.

During an interview with the Administrator on 9/16/22 at 1:56 PM, she revealed there were a lot of new staff that had been hired in the kitchen that have worked for less than a month. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 09/16/2022

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F 812	Continued From page 34 Administrator stated many of the new hires were learning how to work in a health care environment and with time, they will get better and become more educated.	F 812		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide privacy curtains wide enough for full visual privacy around the beds in 2 of 8 rooms on the 100 Hall. (Room 104 and Room 110) The findings included: a. An observation on 9/16/22 at 10:07 AM noted that the privacy curtain for Room #108 did not go completely around bed B. There was approximately 15 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. An interview and observation were conducted with NA #1 on 9/16/22 at 10:10 AM. NA #1 stated that because there was a window and she closed	F 914	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 914] It is the policy of Hillcrest Raleigh at Crabtree Valley, (Hillcrest) to comply with the full visual privacy guidelines as outlined in F914. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The maintenance director replaced the	10/14/22

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F 914	Continued From page 35 the blinds, she did not have to have a full privacy curtain. b. An observation on 9/16/22 at 10:58 AM revealed Room #110 did not have a privacy curtain that extended around bed B. There was approximately 15 feet of insufficient privacy curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. The room was occupied and the curtain for bed A was wide enough. An interview and observation were conducted with the Maintenance Director on 09/16/22 11:14 AM. The visual privacy curtains were observed in room #104 B and room #110 B. The Maintenance Director stated upon visualization of the privacy curtains they were too short. He further stated that sometimes housekeeping put up the wrong size curtains. The Maintenance Director stated that he would notify the Housekeeping Director to have her look at all privacy curtains and have them changed. An Interview was conducted with the Administrator on 09/16/22 03:37 PM. The Administrator stated there were a lot of new staff and the facility was facing situations unseen before. She stated monitoring was constant and the housekeeping staff hung the wrong curtains.	F 914	curtain in room 108B, 104B and 110B with a curtain that will provide sufficient privacy. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The maintenance director and housekeeping manager conducted a thorough inspection of the privacy curtains in all resident rooms immediately following the survey and there were no other concerns noted involving curtains not providing full privacy. All housekeeping and maintenance staff will be in-serviced on ensuring privacy curtains provide full privacy for residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; Monthly, unannounced inspections by the housekeeping manager or her designee are taking place using a facility map and monitoring tool. The goal of this exercise is to continue a monthly inspection until three consecutive inspections indicate no issues of concern and then to maintain this process on a monthly unannounced basis. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and the dates are subject to the vote of this interdisciplinary	

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F 914	Continued From page 36	F 914	committee.	