STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING _____ B. WING _____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 survey was conducted on 12/5/22 through 12/8/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TADH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 12/5/22 through 12/8/22. Event ID# TADH11. The following intakes were investigated: NC00194524; NC00188088; NC0018826; NC00188483; NC00192861; NC000193107; NC00193563; NC00193087; NC193592; NC00195525; NC00195536. 2 of 37 allegations were substantiated resulting in deficiencies. Intakes NC188483, NC193107, NC00193563, NC00193087 and NC193592 resulted in deficiencies.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the Wound Care Nurse Practitioner (NP), the	F 684	The facility sets forth the following plan of correction to remain in compliance with all	12/30/22

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

Electronically Signed | 12/29/2022

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F 684	Continued From page 1 facility failed to schedule consultation of a vascular specialist as ordered for a resident with peripheral vascular disease and recurrent leg wound/swelling for 1 of 4 residents (Resident #61) reviewed with non-pressure related skin conditions. The findings included: Resident #61 was admitted to the facility on 12/1/20. His cumulative diagnoses included peripheral vascular disease and localized edema. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 9/6/22. The MDS assessment indicated Resident #61 had moderately impaired cognition. The resident was reported to have no pressure ulcer and no venous or arterial ulcers present at that time. He received a diuretic on each of 7 days during the 7-day look period. Resident #61's Care Plan included the following area of focus, in part: The resident has non-pressure related potential impairment to skin integrity of bilateral lower extremities related to chronic venous stasis dermatitis (a condition in which the skin becomes swollen or inflamed); Initiated on: 10/11/22. The resident's electronic medical record (EMR) included an order written by the facility's Nurse Practitioner and dated 11/1/22. This order requested a referral to a vascular specialist due to peripheral vascular disease and recurrent leg wound/swelling. Resident #61's EMR also included a Wound/Skin Note which indicated the resident was seen by	F 684	federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F684- Quality of Care 1. Resident #6 now has appointment scheduled for 1/24/22 at 12:45pm 2. All current residents have the potential to be affected by this deficient practice. 3. The Director of Nursing completed a 30-day review of Wound NP nots, wound logs and medical provider orders to ensure that all orders for consults have been communicated to scheduler and consult appointments made. On 12/28/22 the Director of Nursing completed education with current medical providers on the process for ordering consults. 4. All current licensed staff were educated of new process by Director of Nursing on 12/28/22. Any licensed nurse who has not received the education will not be allowed to work until education received. This education will also be added to the new hire process. The Wound NP will communicate orders for consults on the wound log. The Director of Nursing and wound care nurse will review the logs after Wound NP visits to review for any consult recommendations. The medical providers	

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F 684	Continued From page 2 the Nurse Practitioner (NP) Wound Care Specialist on 11/28/22 for reevaluation of left lower extremity venous stasis (a condition in which veins have problems moving blood back to the heart) with ulcerations. Resident #61 was noted to have chronic venous stasis skin changes on his distal lower extremities (the portion of the leg farthest from its point of attachment to the body). He was also reported to have hyperkeratosis (thickening of the outer layer of the skin) and ulcerations on his distal left lower extremity. Some improvement was reported in the ulceration previously noted on his left lower leg and foot. Resident #61 was noted as having evidence of venous disease and assessed to be at risk for wound decline and the development of new venous ulcerations due to his noncompliance with treatment. An interview was conducted on 12/7/22 at 2:00 PM with the Resident's Scheduler. During the interview, the Scheduler reported she did not receive the 11/1/22 order to schedule a vascular consult for Resident #61 until this date (12/7/22). When asked, the Scheduler reported information for a consult was typically given to her by a nurse or the Nurse Practitioner (NP) on either the same day or the day after the order was written. The Scheduler would then call the physician's office, fax information to the office as needed, and set up the necessary appointment. An interview was conducted on 12/7/22 at 2:35 PM with Nurse #3 (who assumed responsibility as the facility's wound care nurse). Nurse #3 stated Resident #61 had been previously seen by the Wound Care Specialist at the facility. However, his wounds were primarily vascular so he was taken off of caseload. She recalled later seeing	F 684	will enter orders for consults into Emar system. The Director of Nursing and Unit Mangers will review order listing report daily. All consults will be communicated to the scheduler by Director of Nursing/Unit Manager or designee. Any consults orders received from the weekend will be reviewed on Monday and communicated to scheduler as needed. The Director of Nursing or designee will complete a daily audit of all new orders to ensure that all ordered consults are scheduled. The audits will be completed daily for 4 weeks and bi-weekly x4 then monthly. 5. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and modifications until a pattern of compliance is achieved. 6. Date of completion: 12.30.2022	

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F 684	Continued From page 3 the resident with the Wound Care Specialist when a whole house skin assessment was conducted. At that time, the decision was made to put Resident #61 back on their caseload. An interview was conducted on 12/7/22 at 3:19 PM with the facility's NP Wound Care Specialist. The NP reported she was now following the resident once a week. She stated, "He is true venous (referring to the vascular condition affecting his skin)." Upon inquiry, the NP stated from her perspective the delay in scheduling a consultation with the vascular specialist was not severe enough to have impacted his wound healing or treatment. An interview was conducted on 12/7/22 at 2:50 PM with the facility's Director of Nursing (DON). During the interview, the DON reported the Resident's Scheduler had only been working in her position for a week or so. The DON reported she would have expected the previous Scheduler to have taken care of arranging Resident #61's appointment with the vascular specialist prior to leaving that position.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		12/30/22

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F 688	Continued From page 4 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed to apply left hand splint for 2 of 2 residents review for range of motion (Resident #68, 69). Findings included: 1.Resident #68 was re-admitted on 8/7/22. Review of her Quarterly Minimum Data Set assessment, dated 8/30/22, indicated her intact cognition. Resident's diagnoses included left hand contracture and hemiplegia (paralysis of one side of the body). Review of Resident 68's plan of care, dated 8/29/22, revealed her limited physical mobility due to left hand contracture with appropriate goals and interventions, included splinting to left upper extremity. Review of the physician's orders for Resident #68 revealed the order, dated 8/30/22, for occupational therapy (OT) evaluation and treatment as indicated for contracture management. Record review revealed the OT discharge summary for Resident #68, dated 9/27/22, indicated that the resident received resting left	F 688	F688 1.Facility failed to ensure that Resident #68 and 69 received the recommended splint as determined by Occupational Therapy. Residents now have proper splints in place and are being used as ordered. 2. Current residents have the potential to be affected. An audit of all residents was completed to ensure that recommended adaptive equipment was in place for identified residents. 3. Education provided to all current nursing staff by the Director of Nursing or designee regarding the following recommendations for hand splints and how to apply splints as ordered. 4.Director of Nursing or designee will audit ordered splints to ensure in place 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then monthly x 1 5. Results of audits will be reviewed at Quarterly Quality Assurance Meeting x 1 for further resolution if needed 6. Date of completion: 12.30.2022	

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F 688	Continued From page 5	F 688		

hand splint application daily from 8/30/22 to 9/27/22, could tolerate it well for four hours. The resident reached maximum potential and was discharged to the nursing floor. The occupational therapy staff trained the nursing staff to apply/remove splint.

Record review of the care tracker for October-November 2022 revealed that Resident #68 did not receive left hand splint applications.

Review of the Medication Administration Records (MAR) for October-November 2022 for Resident #68 revealed no documentation of the left hand splint application.

Record review of the nurses' notes for October-November 2022 revealed no left hand splint application documented for Resident #68.

On 12/5/22 at 9:20 AM, during the observation, Resident #68 was in bed, well dressed and groomed. Her left hand was contracted. The resident did not have splint on her left hand at the time of observation. Resident #68 indicated that she did not receive splint today and could not recall when she had the splint for her left hand last time.

On 12/6/22 at 11:10 AM, during the observation, Resident #68 did not have splint on her left hand. The resident indicated that she did not receive splint today.

On 12/6/22 at 11:30 AM, during an interview, Occupational Therapist (OT #1) indicated that Resident #68 was in the therapy caseload in September 2022 for different problems, including left hand contracture. She received therapy,

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F 688	Continued From page 6	F 688		

made progress and was discharge from the therapy department with recommendation to use resting hand splint for four hours as tolerated. Therapy staff trained nursing staff to apply, remove splint and monitor skin condition.

On 12/6/22 at 11:40 AM, during an interview, Nurse Aide #3 was not sure if Resident #68 had left hand contracture and required the splint application. She was assigned for Resident #68 this shift but did not clarify the left hand contracture situation with the nurse.

On 12/7/22 at 8:40 AM, during an interview, Rehabilitation Director indicated that Resident #68 received OT for left hand contracture, including splinting and was discharged from therapy at the end of September 2022. The therapy staff trained the floor nurses to perform range of motion in preparation to splint application, to apply the splint on resident's left hand for four hours daily and check the skin before and after the procedure.

2. Resident #69 was re-admitted on 8/27/21. Review of his Quarterly Minimum Data Set assessment, dated 9/12/22, indicated his intact cognition. Resident's diagnoses included left hand contracture and hemiplegia (paralysis of one side of the body).

Review of Resident 69's plan of care, dated 9/21/22, revealed his limited physical mobility due to left hand contracture with appropriate goals and interventions, included splinting to left upper extremity.

Review of the physician's orders for Resident #69 revealed the order, dated 9/15/22, for Carrot

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F 688	Continued From page 7	F 688		

device (splint) to left hand daily for 6-8 hours, apply at 7:30 AM , remove at 4 PM. Observe skin with placement and removal. Keep device on medication administration cart.

Review of the Medication Administration Records (MAR) for December 2022 for Resident #69 revealed that the MAR reflected physician's order for left hand splint application and completed on 12/5/22 and 12/6/22.

On 12/5/22 at 9:50 AM, during the observation, Resident #69 was in bed, well dressed and groomed. His left hand was contracted. The resident did not have splint on his left hand at the time of observation. The carrot splint was observed on the nightstand near the bed. Resident #69 indicated that he can remove but cannot apply the carrot splint on hid own. The resident remembered to have the left hand splint last week, but not this morning.

On 12/6/22 at 2:10 PM, during the observation, Resident #69 was in bed, well dressed and groomed. The resident did not have splint on his left hand, and the carrot splint was observed on the nightstand near the bed. Resident #69 indicated that nobody applied the left hand splint for him today.

On 12/6/22 at 8:50 AM, during the observation, Resident #69 was in bed, well dressed and groomed. The resident did not have splint on his left hand, and the carrot splint was observed on the nightstand near the bed. Resident #69 indicated that nobody applied the left hand splint for him today.

On 12/6/22 at 10:40 AM, during an interview,

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Nurse Aide #3 indicated that she was assigned for Resident #69 this shift. Nurse Aide #3 was aware of resident's left hand contracture and splint application order. At the begging of her shift, she observed the carrot splint on the nightstand in resident's room. Resident #69 was asleep, and Nurse Aide #3 did not wake him up. Later, she became busy, and did not apply the carrot splint to the resident. On 12/5/22, Nurse Aide #3 worked first shift with Resident #69 but could not recall if she applied the splint. Nurse Aide #3 confirmed that it was her responsibility to apply the left hand carrot splint according to physician's order.

On 12/6/22 at 10:55 AM, during an interview, Nurse Aide #2 indicated that she was aware of Resident 69's left hand contracture and observed him with carrot splint last week. Today, she did not observe the splint in resident's left hand. Nurse Aide #2 further stated that nurses were responsible for hand splint application.

On 12/6/22 at 1:25 PM, during an interview, Nurse #4, Unit Manager, expected the staff to follow MAR. Nurses were responsible for hand splint application on the floor. Medication Aides, who worked under nurses' supervision, could apply the left hand splint for Resident #69 at 7:30 AM, per order. Nurse #4 was not aware that the resident did not receive splinting on 12/5/22 and 12/6/22.

On 12/7/22 at 10:30 AM, during an interview, Director of Nursing indicated that the therapy department discharged residents to the nursing floor and trained the nursing staff with the correct splint application regiment. The nurse aides could check the assignment sheet and clarify the splint

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F 688	Continued From page 9 application with the nurse. The nurse aide documented the splint applications in the Kiosk (computer) and reported if the resident refused it to the nurse. The nurses documented the splint application in the MAR. On 12/7/22 at 1:10 PM, during an interview, the Administrator expected the staff to follow the orders and plan of care for the splint application and document it appropriately in the MAR.	F 688		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and administration interviews the facility failed to have a Registered Nurse scheduled for 8 consecutive hours a day for 2 (11/26/22 and 11/27/22) of 30 days reviewed. Findings included: A review of the Nursing schedule, dated 11/5/22	F 727	F727 1. On 12/29/2022_the Director of Nursing educated the Nursing Scheduler on the need to ensure a Registered Nurse is scheduled at least 8 hours per day/7 days a week. 2. Center residents in the center have the potential to be affected. The Nursing Scheduler reviewed the scheduled for the	12/30/22

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F 727	Continued From page 10 through 12/5/22, revealed no scheduled Registered Nurse (RN) on 11/26/22 and 11/27/22. Review of the timecards and RN scheduled staffing assignment sheets revealed the facility had no documentation of an RN present in the facility on 11/26/22 and 11/27/22 to meet the requirement for an RN at least 8 consecutive hours per day on each day. On 12/7/22 at 9:45 AM, during an interview, Scheduler indicated that RN should be scheduled every day. Scheduler stated that she had one RN, scheduled on 11/26/22 and 11/27/22, but she quit her job without prior notice. Scheduler reported to the Director of Nursing (DON) on 11/28/22, that on weekend there was no other RN available to cover shifts. On 12/7/22 at 9:55 AM, during an interview, Director of Nursing (DON), indicated that Scheduler posted the schedules, as well as the posted staffing. DON continued that in the case of staff shortages, the on-call staff may be used to cover extra shifts. DON was not aware that on 11/26/22 and 11/27/22, the RN, weekend supervisor, did not show to work (quit without notice). There was no RN available to cover the shifts. DON expected the facility to have an RN staffed to meet the regulation for 8 consecutive hours a day, 7 days a week. On 12/7/22 at 10:15 AM, during an interview, Administrator was aware there were some days an RN was not staffed at the facility, and they did not have a waiver for the daily RN staffing. He expected the Scheduler to staff an RN for 8 hours per day, 7 days a week.	F 727	upcoming four (4) weeks to ensure a Registered Nurse was scheduled for each day. Compliance was noted. 3. The Director of Nursing will continue to review the monthly staffing schedule daily to ensure a Registered Nurse is scheduled for at least 8 hours a day. Any Registered Nurse who cannot work their assigned shift must call in directly to the Director of Nursing. 4. The Administrator, Director of Nursing and reviewed the facilities current recruitment plan for Registered Nurses. 5. The DON/Administrator/designee will monitor the nursing schedule daily to ensure there is 8 hours of consecutive RN coverage for the center. 6. The results of the daily review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists the audits will be completed on a random basis. 7. Date of completion: 12.30.2022	

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff and dispensing pharmacist telephone interviews and record reviews, the facility failed to acquire a medication ordered for	F 755	F755-Pharmacy Services 1. Residents #92, #20, #409 and #159 had all medications reviewed for	12/30/22

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F 755	Continued From page 12 administration resulting in multiple doses of the prescribed medication being missed for 4 of 4 residents (Residents #92, #20, #409 and #159) reviewed for the provision of pharmaceutical services to meet residents' needs. The findings included: 1. Resident #92 was admitted to the facility on 11/4/22. His cumulative diagnoses included delirium due to a known physiological condition, seizure disorder, and a history of metabolic encephalopathy (a condition in which brain function is temporarily or permanently disturbed). The resident's admission orders included a medication order dated 11/4/22 at 10:55 AM for 0.5 milligrams clonazepam (an antianxiety medication which may also be indicated to treat some seizure disorders) to be given as one tablet by mouth two times a day and scheduled for administration at 9:00 AM and 9:00 PM daily. Clonazepam is a controlled substance medication. A review of Resident #92's November 2022 electronic Medication Administration Record (MAR) revealed the clonazepam was documented as administered to the resident on 11/4/22 at 9:00 PM by Nurse #7. Upon further review, the MAR documented clonazepam was not administered to Resident #92 on 11/5/22 (9:00 AM and 9:00 PM), 11/6/22 (9:00 AM and 9:00 PM), and 11/7/22 at 9:00 AM. Documentation on the resident's MAR indicated clonazepam was administered to the resident beginning on 11/7/22 at 9:00 PM and continued as scheduled on 11/8/22.	F 755	availability and were available for administration 2. All current residents receiving medications are at risk for this deficient practice 3. On 12/28/22 all currently licensed nurses were educated by the Staff Development nurse and Director of Nursing on pharmaceutical procedures to assure accurate acquiring, receiving, dispensing and administration of all medications as ordered. If a medication is unable to be administered, the licensed nurse will notify the provider and pharmacy to obtain a hold order or order for alternative treatment if possible. All medications must be administered as ordered. On 12/28/22 the Director of Nursing educated the Admissions team the importance of making sure that all residents have necessary prescriptions for narcotics upon admission to the facility. Any licensed nurse that has not received education will not be allowed to work until education is received. Any newly hired licensed nurse will receive education during the orientation process. 4. The Director of Nursing or designee will audit 10 resident medication records weekly x4 weeks, then bi-weekly x4 weeks then monthly thereafter to monitor for adequate supply. 5. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations	

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F 755	Continued From page 13 Resident #92's Controlled Substance Log (a declining inventory) for 0.5 mg clonazepam revealed this medication was dispensed by the facility's contracted pharmacy on 11/7/22 and received by the facility on 11/7/22. The first dose of clonazepam was withdrawn from the medication dispensed for this resident on 11/7/22 at 9:00 PM. An interview was conducted with Nurse #7 on 12/8/22 at 8:00 AM. Nurse #7 was identified by her initials on Resident #92's MAR as having been assigned to pass medications to the resident on the evening of 11/4/22. During the interview, the nurse was asked about the documentation on Resident #92's MAR which indicated his clonazepam was administered on 11/4/22 at 9:00 PM. The nurse stated she specifically recalled this situation and reported his controlled substance had not yet come in to the facility. Nurse #7 stated she must have made an error in the documentation and reiterated his clonazepam was not available to be administered on 11/4/22 so he did not receive the medication. The nurse reported at the time of Resident #92's admission, she worked as an agency (temporary) nurse at the facility. She stated that to her knowledge, none of the agency nurses had access to the Omnicell (an automated dispensing medication cabinet utilized as an emergency medication stock). Nurse #7 reported at one point she had inquired about possibly acquiring needed medications from a back-up pharmacy but she did not receive a response. In the presence of the facility's Director of Nursing (DON), a telephone interview was conducted on 12/8/22 at 11:52 AM with a dispensing pharmacist from the facility's contracted pharmacy. During	F 755	and modifications until a pattern of compliance is achieved. 6. Date of completion: 12.30.2022	

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the interview, the pharmacist confirmed the pharmacy first dispensed clonazepam for Resident #92 on 11/7/22. Upon inquiry, the pharmacist reported medications were sent out from the pharmacy twice a day, 7 days a week. The cut off time for medication requests was 12:00 PM for meds to be delivered at 2:00 PM and the evening cut off time was 12:00 AM for medications to be delivered to the facility at 2:00 AM each day. She added that "we stat it out" if medications were needed for a resident before the scheduled delivery time. Alternatively, the pharmacy could arrange to call the facility's back up pharmacy to fill a medication order, if needed.

An interview was conducted on 12/8/22 at 12:44 PM with the facility's DON. During the interview, the DON reported she would expect a controlled substance medication to be acquired for a resident within 24 hours. She stated she would expect it to be available for a resident even sooner if the medication was stocked in the facility's Omnicell. During a follow-up interview conducted on 12/8/22 at 1:22 PM, the DON reported the clonazepam ordered for Resident #92 was not available via the Omnicell. She stated it appeared the facility needed to be certain prescriptions (scripts) were sent from the hospital with a resident when he/she was admitted to the facility with an order for a controlled substance medication. The DON reported sometimes the scripts were sent out from the hospital with the resident and sometimes they were not.

2. Resident #20 was admitted to the facility on 11/11/22. His cumulative diagnoses included generalized anxiety disorder and sleep disorder.

The resident's admission orders included a

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medication order dated 11/11/22 at 9:13 PM for 0.5 milligrams alprazolam (an antianxiety medication) to be given as one tablet by mouth at bedtime and scheduled for administration at 9:00 PM daily. Alprazolam is a controlled substance medication.

A review of Resident #20's November 2022 electronic Medication Administration Record (MAR) revealed the alprazolam was not administered on 11/11/22, 11/12/22, or 11/13/22. Documentation on the resident's MAR indicated the first dose of alprazolam was administered to the resident on 11/14/22.

Resident #20's Controlled Substance Log (a declining inventory) for 0.5 mg alprazolam revealed this medication was dispensed by the facility's contracted pharmacy on 11/14/22 and received by the facility on 11/14/22.

An interview was conducted with Nurse #7 on 12/8/22 at 8:00 AM. Nurse #7 was identified by her initials on Resident #20's MAR as having been assigned to pass medications to the resident on the evening of 11/13/22. During the interview, the nurse was asked about the instance when Resident #20 was first admitted to the facility and his alprazolam not given as scheduled on the evening of 11/13/22. The nurse stated she did not recall this particular situation. However, she reported his alprazolam likely had not come in to the facility from the pharmacy and she did not have access to the facility's Omnicell (an automated dispensing medication cabinet utilized as the facility's emergency medication stock) at that time. Nurse #7 reported at the time of Resident #20's admission, she worked as an agency (temporary) nurse at the facility and to her

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knowledge, none of the agency nurses had access to the Omnicell. Nurse #7 stated at one point she had inquired about possibly acquiring needed medications from a back-up pharmacy but she did not receive a response.

In the presence of the facility's Director of Nursing (DON), a telephone interview was conducted on 12/8/22 at 11:52 AM with a dispensing pharmacist from the facility's contracted pharmacy. During the interview, the pharmacist confirmed Resident #20's alprazolam was first dispensed from the pharmacy on 11/14/22. Upon inquiry, the pharmacist reported medications were sent out from the pharmacy twice a day, 7 days a week. The cut off time for medication requests was 12:00 PM for meds to be delivered at 2:00 PM and the evening cut off time was 12:00 AM for medications to be delivered to the facility at 2:00 AM each day. She added that "we stat it out" if medications were needed for a resident before the scheduled delivery time. Alternatively, the pharmacy could arrange to call the facility's back up pharmacy to fill a medication order, if needed.

An interview was conducted on 12/8/22 at 12:44 PM with the facility's DON. During the interview, the DON reported she would expect a controlled substance medication to be acquired for a resident within 24 hours. She stated she would expect the medication to be available for a resident even sooner if the medication was stocked in the facility's Omnicell. During a follow-up interview conducted on 12/8/22 at 1:22 PM, the DON reported the alprazolam ordered for Resident #20's was not available via the facility's Omnicell. She stated it appeared the facility needed to be certain prescriptions (scripts) were sent from the hospital with a resident when

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he/she was admitted to the facility with an order for a controlled substance medication. The DON reported sometimes the scripts were sent out from the hospital with the resident and sometimes they were not.

3. Resident #409 was admitted to the facility on 8/30/21. Her cumulative diagnoses included a fracture of the left pubis (a pair of bones forming the two sides of the pelvis).

The resident's admission orders included an order dated 8/30/21 at 5:27 PM for 7.5 milligrams (mg) clorazepate (an antianxiety medication) to be given as one tablet by mouth two times a day for anxiety related to a fracture of the left pubis. A notation made with the order read, "may administered medication from home until pharmacy delivers." Clorazepate was scheduled for administration at 9:00 AM and 6:00 PM daily. Clorazepate is a controlled substance medication.

A review of Resident #409's August 2021 electronic Medication Administration Record (MAR) revealed clorazepate was not administered on 8/30/21 at 6:00 PM or on 8/31/21 at 9:00 AM. The medication was documented as administered on 8/31/21 at 6:00 PM. Review of Resident #409's September MAR revealed clorazepate continued to be administered twice daily in accordance with the physician orders.

A review of the facility's Omnicell Inventory listing revealed clorazepate was not available for use. An Omnicell is an automated dispensing medication cabinet utilized as an emergency medication stock for the facility.

In the presence of the facility's Director of Nursing

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(DON), a telephone interview was conducted on 12/8/22 at 11:52 AM with a dispensing pharmacist from the facility's contracted pharmacy. During the interview, the pharmacist reported Resident #409's clorazepate was first dispensed from the pharmacy on 9/2/21 (3 days after the resident was admitted to the facility). When asked, the pharmacist reported medications were sent out from the pharmacy twice a day, 7 days a week. The cut off time for medication requests was 12:00 PM for meds to be delivered at 2:00 PM and the evening cut off time was 12:00 AM for medications to be delivered to the facility at 2:00 AM each day. She added that "we stat it out" if medications were needed for a resident before the scheduled delivery time. Alternatively, the pharmacy could arrange to call the facility's back up pharmacy to fill a medication order, if needed.

An interview was conducted on 12/8/22 at 12:44 PM with the facility's DON. During the interview, the DON reported she would expect a controlled substance medication to be acquired for a resident within 24 hours. She stated she would expect the medication to be available for a resident even sooner if the medication was stocked in the facility's Omnicell.

4. Resident #159 was admitted to the facility on 5/7/22 with re-entry from a hospital on 6/30/22. Her cumulative diagnoses included chronic pain, diabetic polyneuropathy, a left below knee amputation and phantom limb syndrome with pain.

The resident's September 2022 medication orders included an order originally dated 6/30/22 for 7.5 milligrams (mg) / 325 mg oxycodone / acetaminophen (a combination opioid pain

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medication) to be given as one tablet by mouth every 6 hours as needed (PRN) for pain. Oxycodone / acetaminophen is a controlled substance medication.

A review of Resident #159's September 2022 electronic Medication Administration Record (MAR) and Controlled Substance Logs (declining inventory records) revealed her PRN oxycodone / acetaminophen was administered to the resident 1 to 4 times on 28 days during that month for a pain level ranging from "4" to "10" using a scale of 0 to 10 (with 0 indicative of no pain). Neither the MAR nor the Controlled Substance Logs indicated oxycodone / acetaminophen was given to Resident #159 on 9/12/22 or 9/13/22.

On 9/13/22, Resident #159's electronic medical record (EMR) documented her level of pain was "5." However, no doses of the PRN oxycodone / acetaminophen were documented as having been administered. The resident's Controlled Substance Logs indicated her PRN pain medication was not available for administration. A review of the Omnicell Inventory listing also revealed 7.5 / 325 mg oxycodone / acetaminophen was not available for use. An Omnicell is an automated dispensing medication cabinet utilized as an emergency medication stock for the facility.

Further review of Resident #159's Controlled Substance Logs revealed the last dose of oxycodone / acetaminophen received from the pharmacy on 8/31/22 was administered to the resident on 9/11/22 at 9:00 PM. Another Controlled Substance Log indicated 30 tablets of 7.5 / 325 mg oxycodone / acetaminophen were dispensed by the pharmacy for Resident #159 on

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9/13/22. The first dose of oxycodone / acetaminophen was withdrawn from this new inventory of medication on 9/14/22 at 6:00 AM for Resident #159.

Nurse #8 was identified by her initials on Resident #159's MAR as having been assigned to pass medications to the resident during the day shift of 9/12/22 and 9/13/22. However, Nurse #8 was no longer employed by the facility and could not be contacted for an interview.

An interview was conducted on 12/8/22 at 10:53 AM with Medication (Med) Aide #1. Med Aide #1 was identified by her initials on Resident #159's MAR as having been assigned to pass medications to the resident on the evenings of 9/12/22 and 9/13/22. During the interview, the Med Aide recalled Resident #159 but could not specifically recall a time when the resident was out of her oxycodone / acetaminophen when she may have needed it.

In the presence of the facility's Director of Nursing (DON), a telephone interview was conducted on 12/8/22 at 11:52 AM with a dispensing pharmacist from the facility's contracted pharmacy. During the interview, the pharmacist confirmed in addition to the oxycodone / acetaminophen dispensed on 9/13/22, this medication was dispensed from the pharmacy for Resident #159 on 10/3/22, 10/16/22 and 10/26/22 (prior to her discharge from the facility on 11/1/22). Upon inquiry, the pharmacist reported medications were sent out from the pharmacy twice a day, 7 days a week. The cut off time for medication requests was 12:00 PM for meds to be delivered at 2:00 PM and the evening cut off time was 12:00 AM for medications to be delivered to the

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F 755	Continued From page 21 facility at 2:00 AM each day. She added that "we stat it out" if medications were needed for a resident before the scheduled delivery time. Alternatively, the pharmacy could arrange to call the facility's back up pharmacy to fill a medication order, if needed. An interview was conducted on 12/8/22 at 12:44 PM with the facility's DON. During the interview, the DON reported she would expect a controlled substance medication to be acquired for a resident within 24 hours. She stated she would expect the medication to be available for a resident even sooner if the medication was stocked in the facility's Omnicell.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 32 opportunities, resulting in a medication error rate of 6.2% for 2 of 5 residents (Resident #93 and Resident #410) observed during medication pass. The findings included: 1. On 12/6/22 at 9:35 AM, Nurse #6 was observed as she prepared medications for administration to Resident #93. The medications	F 759	F759-Free of Medication Errors 1. Cart audits were completed for all carts to assure all medications had current expiration dates. Notification was made to medical provider regarding application of gel to incorrect site. 2. All residents are at risk for deficient practice therefore all licensed nurses received education of the six rights of medication administration, appropriate storage, labeling of medications and the facilities□ medication administration	12/30/22

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F 759	Continued From page 22 prepared for administration included 0.5 milligrams (mg) / 1 milliliter (ml) of lorazepam gel. Nurse #6 was observed as she brought the prepared medications into Resident #93's room for administration and applied the lorazepam gel to the resident's left lower arm. A review of Resident #93's current orders included the following, in part: "Lorazepam Gel 0.5 mg/ml Apply (to) 1 ml to back topically three times a day for anxiety (Order Date 7/14/22)." An interview was conducted on 12/6/22 at 12:26 PM with Nurse #6. During the interview, a concern regarding the topical administration site of the lorazepam gel for Resident #93 was discussed. During the interview, the nurse reviewed Resident #93's Medication Administration Record (MAR). She confirmed the instructions for the lorazepam gel indicated it was supposed to be applied topically to the resident's back. Nurse #6 stated she was not aware of this and reported she should have applied the lorazepam gel to his back instead of his arm. An interview was conducted on 12/6/22 at 1:05 PM with Nurse #4 (who also assumed responsibilities as a Unit Manager for the facility). During the interview, Nurse #4 reported it would be expected for lorazepam gel to be applied topically to the site indicated in the physician's order. An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the medication (med) administration concerns identified during the med pass observations were discussed. Upon inquiry, the DON stated her expectation would be for the	F 759	policy. 3. On 12/28/22 all licensed nurses were re-educated on the six rights of medication administration and appropriate labeling and storage of medications. A new schedule has been initiated for night shift nurses to perform weekly cart audits to review for expiration of medications and appropriate storage and labeling of medications. Any licensed nurse or staff performing medication administration that have not been educated will not be allowed to work until educated. This education will also be added to the new hire process. 4. The Director of Nursing or designee will observe 2 random medication administration observations on all shifts. This monitoring will be conducted 3x per week for 4 weeks then weekly x 4 weeks, then monthly thereafter. 5. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and modification until a pattern of compliance is achieved. 6. Date of completion: 12.30.2022	

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F 759	Continued From page 23	F 759		

nurse to apply lorazepam gel to the site indicated in the medication order.

2. On 12/7/22 at 7:54 AM, Nurse #5 was observed as she prepared medications for administration to Resident #410. The medications prepared for administration included one tablet of 50 milligrams (mg) zinc. Nurse #5 was observed as she removed one-50 milligram (mg) zinc tablet from a stock bottle on the medication (med) cart and placed it into a med cup containing 5 other tablets ready for administration to the resident. She replaced the stock bottle of zinc into the med cart and began to pull another medication for this resident. At that time, the nurse was asked to remove the stock bottle of zinc from the medication and confirm the expiration date. The nurse pointed to the handwritten date on the stock bottle which indicated it had been first opened on 12/2/22. She was then shown the manufacturer's expiration date of 11/22 (November 2022) printed on the stock bottle. Upon further review, the nurse stated, "Good catch." Nurse #5 was observed as she separated the expired stock bottle of zinc tablets from the other stock meds on the cart, replaced it with a new bottle of 50 mg zinc tablets (with an expiration date of 12/23) from the med room, and re-pulled Resident #410's medications. At that time, the nurse reported she was going to administer 4 - 50 mg zinc tablets as a partial dose to the resident and send a note to the prescriber for clarification of the order because the order was for 220 mg zinc.

A review of Resident #410's current medication orders included an order for 220 mg zinc to be given as one capsule by mouth one time a day (Order Date 12/1/22).

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F 759	Continued From page 24 An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the medication (med) administration concerns identified during the med pass observations were discussed. Upon inquiry, the DON stated her expectation was for the nursing staff to check the expiration date of a medication when preparing it for administration to the resident.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		12/30/22

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F 761	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to: 1) Discard expired medications stored in 3 of 3 medication (med) carts observed (200 Middle Hall Med Cart; 200 High Hall Med Cart; and the 100 High Hall Med Cart); and 2) Store medications in accordance with the manufacturer's storage instructions in 1 of 3 med carts observed (200 High Hall Med Cart). The findings included: 1-a. Accompanied by Nurse #4, an observation of the 200 Middle Hall Med Cart was conducted on 12/6/22 at 1:05 PM. The observation revealed an opened insulin glargine pen (a long-acting insulin) dispensed by the pharmacy for Resident #1 was stored on the medication cart. A hand-written notation on the insulin pen indicated it was opened on 10/25/22. Manufacturer labeling on the insulin pen read, "Use within 28 days after initial use." At the time of the observation, Nurse #4 confirmed the insulin glargine pen was expired. She was observed to discard the insulin glargine pen. A review of the manufacturer's storage instructions for an insulin glargine pen revealed prefilled pens that have been opened (in use) should be used within 28 days. A review of Resident #1's Physician Orders revealed there was a current order for insulin glargine to be injected as 15 units subcutaneously (under the skin) at bedtime (Order Date 10/4/21). An interview was conducted on 12/7/22 at 9:40	F 761	F761-Label/Store Drugs and Biologicals 1. No residents were affected by this deficient practice. 2. All current residents have the potential to be affected. 3. On 12/30/22 all current nurses received education from the Director of Nursing related to med pass procedures including six rights, checking for expiration dates, and ensuring the site of application for topical medications confirmed before application. A new schedule has been initiated for night shift nurses to perform weekly cart audits to review for expiration of medications and appropriate storage and labeling of medications. All expired medications will be immediately removed from the carts. Any licensed nurse or staff performing medication administration that have not been educated will not be allowed to work until educated. This education will also be added to the new hire process. 4. The Director of Nursing or designee will do a random audits for 10 residents on each med cart weekly. This monitoring will be conducted weekly for 4 weeks then bi-weekly x 4, then monthly thereafter. 5. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations	

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AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for all insulin pens to be dated when opened. She also stated that nursing staff were expected to check the expiration date of an insulin pen and to remove it from the med cart when the pen was expired.

1-b. Accompanied by Nurse #6, an observation of the 200 High Hall Med Cart was conducted on 12/6/22 at 9:45 AM. The observation revealed an opened insulin glargine pen (a long-acting insulin) dispensed by the pharmacy on 10/26/22 and labeled for Resident #19 was stored on the medication cart. A hand-written notation on the insulin pen indicated it was opened on 10/31/22. Manufacturer labeling on the insulin pen read, "Use within 28 days after initial use."

An interview was conducted with Nurse #6 on 12/6/22 at 12:58 PM. At that time, Nurse #6 reported the expired insulin glargine pen stored on the med cart for Resident #19 had been discarded.

A review of the manufacturer's storage instructions for an insulin glargine pen revealed prefilled pens that have been opened (in use) should be used within 28 days.

A review of Resident #19's Physician Orders revealed there was a current order for insulin glargine to be injected as 8 units subcutaneously (under the skin) every 12 hours (Order Date 9/27/22).

An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her

and modification until a pattern of compliance is achieved.

6. Date of completion: 12.30.2022

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expectation was for all insulin pens to be dated when opened. She also stated that nursing staff were expected to check the expiration date of an insulin pen and to remove it from the med cart when the pen was expired.

1-c. A medication storage observation was completed of the 200 High Hall Med Cart on 12/6/22 at 12:50 PM with Nurse #6. The observation revealed a stock bottle of 325 milligrams (mg) enteric coated aspirin was stored on the med cart. The stock bottle had 5 tablets remaining in the bottle with a manufacturer expiration date of 9/22 (September 2022).

An interview was conducted with Nurse #6 on 12/6/22 at 12:58 PM. During the interview, Nurse #6 confirmed the stock bottle of 325 mg enteric coated aspirin was expired.

An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her expectation was for nursing staff to check the expiration date of a medication and to remove any expired medications from the med cart.

1-d. During a medication administration observation conducted on 12/7/22 at 7:54 AM with Nurse #5, a stock bottle of 50 milligrams (mg) zinc stored on the 100 High Med Cart was found to have a manufacturer expiration date of 11/22 (November 2022). An interview with Nurse #5 confirmed the stock bottle of medication was expired.

An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the DON reported her

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expectation was for nursing staff to check the expiration date of a medication and to remove any expired medications from the med cart.

2-a. Accompanied by Nurse #6, an observation of the 200 High Hall Med Cart was conducted on 12/6/22 at 12:50 PM. The observation revealed three (3) vials of 0.5 milligram (mg) and 3 mg / 3 milliliter (ml) ipratropium / albuterol inhalation solution (an inhaled medication used for the management of chronic obstructive pulmonary disease) dispensed for Resident #3 were laying at the bottom of a manufacturer's box stored in the medication cart. These vials were not stored inside of a foil pouch. A yellow auxiliary sticker placed on the manufacturer's box by the dispensing pharmacy read, " ...keep unused vials in foil pouch."

An interview was conducted on 12/6/22 at 12:58 PM with Nurse #6. During the interview, the nurse was shown the manufacturer's information and auxiliary sticker placed on the ipratropium/albuterol vials for inhalation. When asked, the nurse reported she had not previously been aware of these instructions.

A review of the manufacturer's storage instructions for ipratropium/albuterol inhalation solution indicated vials should be protected from light before use. Unused vials should be placed in the foil pouch for storage.

A review of Resident #3's Physician Orders revealed there was a current order for 0.5 - 2.5 (3) mg / 3 ml ipratropium - albuterol inhalation solution to be inhaled orally three times a day (Order Date 8/19/22).

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An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the DON reported vials of ipratropium - albuterol solution for inhalation should be kept stored in the foil pack.

2-b. Accompanied by Nurse #6, an observation of the 200 High Hall Med Cart was conducted on 12/6/22 at 12:50 PM. The observation revealed three (3) vials of 0.5 milligram (mg) and 3 mg / 3 milliliter (ml) ipratropium / albuterol inhalation solution (an inhaled medication used for the management of chronic obstructive pulmonary disease) dispensed for Resident #51 were laying at the bottom of a manufacturer's box stored in the medication cart. These vials were not stored inside of a foil pouch. The labeling on the manufacturer's box of vials included Storage Conditions which read, in part: "Protect from light. Store in pouch until time of use..."

An interview was conducted on 12/6/22 at 12:58 PM with Nurse #6. During the interview, the nurse was shown the manufacturer's storage instructions on the ipratropium/albuterol vials for inhalation. When asked, the nurse reported she had not previously been aware of these instructions.

A review of the manufacturer's storage instructions for ipratropium/albuterol inhalation solution indicated vials should be protected from light before use. Unused vials should be placed in the foil pouch for storage.

An interview was conducted on 12/7/22 at 9:40 AM with the facility's Director of Nursing (DON). During the interview, the DON reported vials of ipratropium - albuterol solution for inhalation

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F 761	Continued From page 30 should be kept stored in the foil pack.	F 761		
F 812 SS=F	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 keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the ceiling vents and air condition units located over the food prep and food service area. This practice had the potential to affect food served to all residents. Findings included: 1.During a kitchen tour on 12/5/22 at 10:00 AM,	F 812	F812 1. The stove, steam table, fryer, plate warmer and ceiling vents were cleaned. 2. All residents are at risk for this alleged deficient practice. 3. On 12/30/22 dietary staff were educated by the dietary manager on the new cleaning schedule, checklist and cleaning procedures. Dietary manager created a new cleaning schedule and checklist to assure that appropriate cleaning procedures are followed on a routine basis.	12/30/22

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F 812	Continued From page 31 the following observations were made with the kitchen Supervisor: a. The 9- stove burners had a heavy grease build up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. Follow-up observation on 12/7/22 at 11:30 AM, the following observations were made of the identified kitchen equipment, ceiling vents and air condition remained the same as the initial tour on 12/5/22. b. The 4-compartment ovens had a heavy grease buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a dried grease buildup was observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven. c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. In addition, the fryer had heavy grease and food build up inside and outside, food products behind the fryer. e. The 5 compartment steam tables had large volumes of dried food and liquid matter encrusted on the edges inside/outside. In addition, the steam table also had left over food in standing water, the pans were heavy encrusted with brown matter and burnt food items.	F 812	4. Newly hired dietary employees will receive the above training as appropriate for their individual job duties. The Dietary Manager will provide the Staff Development Coordinator with proof that the employee has had the appropriate training and can demonstrate competency prior to the employee working independently. 5. This monitoring will be conducted weekly for 4 weeks then bi-weekly x 4, then monthly thereafter. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and modification until a pattern of compliance is achieved. 6. Date of completion: 12.30.2022	

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f. The 2 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around.

G The 6 ceiling vents and 2 air conditions had large volumes of black dust/debris blowing over food service and prep surfaces.

An interview was conducted on 12/5/ 22at 10:15 AM, the Kitchen Supervisor stated staff were required to wipe down oven/stove should be wiped down after each meal and deep cleaned weekly. The Kitchen Supervisor further stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly. He added the kitchen equipment should be wiped down daily and cleaned weekly in accordance with the kitchen cleaning checklist. The Kitchen Supervisor acknowledged the identified kitchen equipment, ceiling fan and air condition units had not been cleaned in several months. The Kitchen Supervisor was unable to present a cleaning checklist.

Follow-up interview on 12/7/22 at 11:39 AM, the Dietary Manager (DM) and Kitchen Supervisor was present. The DM stated he did not have a system in place to ensure the kitchen equipment, ceiling vents and air condition units were cleaned on a regular basis. The DM further stated he did not know when the last time the ceiling vents or air condition had been cleaned. The DM acknowledged the vents and air condition needed to be cleaned. The Kitchen Supervisor further stated he attempted to clean some of the identified equipment but did not have enough time to complete the task. He added there was

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F 812	Continued From page 33 not a specific cleaning checklist being used at this time. The equipment was being cleaned as it was used. An interview was conducted on 12/7/22 at 12:24 PM, the Administrator stated the Dietary Manager and Kitchen Supervisor was responsible for ensuring the kitchen was cleaned and maintained. The expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance with kitchen sanitation guidelines.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview and record review, the facility's quality assurance and performance improvement (QAPI) process failed to implement, monitor, and revise as needed the action plan developed for the recertification dated 7/30/21 to achieve and sustain compliance. This was repeated deficiencies on a recertification survey on 12/8/22. The deficiencies were in the areas of Medication Error rate of greater than 5% and Food procurement and Store/Prepare/Serve - Sanitary condition. This deficiency was recited in the current recertification survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to	F 867	F867 1. The Facility Quality Assurance Performance Improvement (QAPI) committee will review the findings identified during annual survey on 12/5/22-12/8/22. 2. The Facility Administrator will conduct the meeting that includes participation of the interdisciplinary team members as well as the Medical Director. Meeting agenda will consists the areas of concern identified during the annual survey to include, Quality of Care (F684),	12/30/22

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F 867	Continued From page 34 sustain an effective Quality Assurance (QA) Program. The findings included: These tags were cross referenced to: F759 Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 32 opportunities, resulting in a medication error rate of 6.2% for 2 of 5 residents (Resident #93 and Resident #410) observed during medication pass. During the previous recertification and complaint survey on 7/30/22, the facility's medication error rate greater than 5% as evidenced by 10 medication errors out 29 opportunities. There were medication errors for 1 of 4 residents during medication pass observations. The medication error rate was 34.8%. F812 Based on observations and staff interviews, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the ceiling vents and air condition units located over the food prep and food service area. This practice had the potential to affect food served to all residents. During the previous recert and complaint survey on 7/30/22, the facility failed to label and dated stored food items in the walk-in freezer, discard food with expired used by date in the walk-in refrigerator, ensure bread products were labeled so staff knew how long the bread could be utilized and discard food in 1 of 2 nourishment	F 867	Increase/Prevent decrease in mobility (F688), RN 8 Hours/7days/week/FT DON (F727), Pharmacy/Services/Procedures/Records (F755), Free of Medication Errors rate 5% or more (F759), Label/Storage of Drugs/biologicals (F761), Food Procurement/Storage prepare/Serve sanitation (F812), QAPI/QAA Improvement activities (F867). 3. Findings identified will have a plan of correction in place to include immediate correction, quality review, education and ongoing quality improvement monitoring in place to be reviewed by QAPI committee. On 12/28/22, the Facility Administrator and Director of Nursing were educated regarding conducting an effective QAPI committee that identifies areas of concern, using Root Cause Analysis, development of a Performance Improvement Plan (PIP) that includes goals, actions taken, person responsible, completion date, and results. 4. On 12/30/22, the Facility Administrator will present the Plan of Correction to the Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Facility Administrator, Director of Nursing and or designee. QAPI committee to meet weekly for four weeks, then as indicated based on the QAPI findings, but at a minimum monthly thereafter to review performance improvement related to areas identified during the annual survey 12/5/22-12/8/22.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

(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 867	Continued From page 35 refrigerators reviewed for food storage. The facility failed to label and date food items in 1 of 2 nourishment refrigerators (300/400 hall). The failure had the potential to affect food served to residents. During an interview on 12/7/22 at 12:45 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. The Administrator indicated when problem areas were identified the quality assurance and performance improvement (QAPI) plan was laid out. Individual staff should report progress or lack of progress and reason for the lack of progress. The root cause should be analyzed, and all effort should be made to resolve this issue. The team should continuously monitor until the deficient area concerns have been resolved.	F 867	5.The Vice President of Operations and or Regional Director of Clinical Services will monitor and review the findings monthly for four months and randomly thereafter. Quality Monitoring schedule may be modified based on quality monitoring findings 6. Date of compliance. 12.30.2022	