STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345507	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/06/23 through 02/09/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID # C2R111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted on-site from 2/6/23 through 2/9/23. Event ID # C2R111. 1 of the 1 complaint allegations did not result in a deficiency. Intake #NC00196299.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		3/6/23

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

Electronically Signed | 03/02/2023

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Physician and Nurse Practitioner interviews the facility failed to notify the Physician or Nurse Practitioner to discontinue an NPO (nothing by mouth) order and to resume medications following notification that a surgical procedure had been rescheduled for a later date for 1 of 1 resident reviewed. (Resident #66). Findings included. Resident #66 was admitted to the facility on	F 580	F580 Nurse Practitioner was notified by the unit manager on 2/8/2023 that the appointment was cancelled for resident #66. All appointments scheduled on or after 1/20/2023 were reviewed by the Unit Manager on 2/20/2023 to ensure no one had missed a schedule appointment and that the Provider was notified. There were	

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F 580	Continued From page 2 08/27/21 with diagnoses including bilateral kidney mass, benign prostatic hyperplasia (BPH-enlarged prostate) with urinary tract symptoms, urine retention, heart disease, peripheral artery disease, diabetes, and mood disorder. The Minimum Data Set (MDS) assessment dated 12/05/22 revealed Resident #66 was severely cognitively impaired and required extensive assistance with activities of daily living (ADLs). Record review revealed Resident #66 was scheduled for urology procedures for Cystolitholapaxy (surgical procedure to treat bladder stones) and for Transurethral resection of the prostate (TURP- surgical procedure to treat urinary problems caused by an enlarged prostate). The procedures were scheduled for 02/08/23 at 11:00 AM. A pre-surgical order dated 01/16/23 for Resident #66 was in place to remain NPO (nothing by mouth) after midnight the day before surgery on 02/08/2023. A pre-surgical order dated 01/16/23 for Resident #66 was in place to hold Plavix oral tablet 75 milligrams (antiplatelet) administered once a day for peripheral arterial disease seven days prior to the procedure from 02/02/23 through 02/08/23. A pre-surgical order dated 01/16/23 for Resident #66 was in place instructing that medications to take the morning of surgery with a sip of water included Seroquel (antipsychotic), Metoprolol (antihypertensive) and Flomax (alpha blocker for treatment of enlarged prostate) prior to surgery on 02/08/23.	F 580	two missed appointments identified for current residents that had not been reported to the Provider. The unit manager documented the practitioner notification in the Electronic Medical Record for each resident on 2/20/2023. The Director of Nursing or designee will educate the transportation staff on informing nurses when appointments are cancelled by 2/24/2023 and education will be provided to the nurses by the Director of Nursing or designee by 2/24/2023 on notifying the provider of appointment cancellations and reviewing orders related to the cancelled appointments. All appointments will be audited 5x week for 12 weeks to ensure each appointment is kept, any cancellations are reported to the Provider, orders have been reviewed and that documentation is accurate in the Electronic Medical Record. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months. Plan of correction may be modified or audits extended to ensure ongoing compliance.	

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F 580	Continued From page 3	F 580		

During an interview with Nurse #1 on 02/08/23 at 1:30 PM she stated Resident #66 had been NPO since midnight on 02/08/23, his Plavix had been held for 7 days, and only received his Seroquel, Metoprolol, and Flomax earlier that morning in preparation of the surgical procedure which they thought was scheduled for 11:00 AM. She stated when transport never showed up, she asked about it and was told by the facility transporter that the procedure was not scheduled for today. She stated the Nurse Practitioner was notified by the unit manager at that time and orders were received to discontinue the NPO order and resume medications for Resident #66. She stated she was not made aware that the procedure date was changed until that time.

An interview was conducted on 02/08/23 at 3:32 PM with the facility transporter. He stated on 01/16/23 he was notified by urology that the procedure for Resident #66 was scheduled for 02/08/23 at 11:00 AM at the hospital surgical pavilion and instructions were given to hold Plavix for 7 days and NPO after midnight prior to the procedure. He stated two days ago on 02/06/23 around 2:30 PM the urology office called the facility to schedule another appointment for Resident #66. He stated he informed urology that the resident had an appointment scheduled this week on 02/08/23 for a procedure at the surgical pavilion and urology informed the transporter at that time that Resident #66 did not have an appointment scheduled for 02/08/23 that the appointment was scheduled for 03/08/23. The facility transporter stated he notified the residents nurse (#10) on Monday 02/06/23 that the procedure would not be on 02/08/23. He stated he notified the unit manager the following day on 02/07/23 that the procedure was not going to be

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F 580	Continued From page 4	F 580		

this week.

An interview was conducted on 02/08/23 at 4:08 PM with Nurse #10. She stated she was informed by the transporter that the procedure for Resident #66 was not scheduled this week but could not recall if it was Monday or Tuesday when she was notified. She stated she did not notify anyone and indicated she did not notify the provider on 02/06/23 to get orders to discontinue the NPO order and resume his medications. She stated she thought that was handled by someone else.

An interview was conducted on 02/08/23 at 4:36 PM with the unit manager. She stated the facility transporter did notify her late in the day on 02/07/23 but she thought the transporter meant that he was unsure whether or not the procedure was this week. She stated she misunderstood when he notified her and indicated she should have followed through with it and notified the physician to get orders to discontinue the NPO order and resume the medications for Resident #66.

An interview was conducted with the Physician on 02/09/23 at 11:30 AM. He stated he was not aware of the date of the scheduled procedure for Resident #66. He indicated if the procedure was not this week and orders were in place to have resident NPO and hold medications then the nurse should have notified him or the Nurse Practitioner on 02/06/23 to discontinue the NPO order and resume medications. He stated Resident #66 not receiving Plavix Monday through Wednesday had no significance and would not cause any harm or concern.

During an interview on 02/09/23 at 12:08 PM with

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F 580	Continued From page 5 the Nurse Practitioner she stated she was notified the afternoon of 02/08/23 of the mix up in the schedule and that the procedure did not occur. She stated orders were given at that time to the unit manger to discontinue the NPO order and resume medications for Resident #66. During an interview on 02/09/23 at 3:41 PM the Director of Nursing (DON) stated Nurse #10 should have notified the provider on 02/06/23 when the transporter told her that the appointment was not scheduled this week for Resident #66 and obtained orders to discontinue the NPO order and resume medications.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/9/23

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F 584	Continued From page 6 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain walls in resident rooms and resident care area hallways in good repair and failed to repair or replace torn or stained linoleum and a threshold in resident bathrooms. This was for 9 of 18 resident rooms and 3 of 3 hallways reviewed for homelike environment (Rooms 201, 206, 207, 305, 306, 605, 607, 609, the 200 and 300 hallways and wall on the hallway in front of the the North Side nurses station area). Findings included: During a tour of the facility on 2/8/23 at 12:20 PM the following observations were made: a. The 200 hallway was observed with scratches on the walls and damage to the wallpaper.	F 584	F584 Safe/Clean/Comfortable/Homelike Environment All items listed as "a". through "k" on this statement of deficiencies will be corrected by the facility maintenance staff or an outside contractor by 3/9/23. Education was provided to the administrative team by the administrator on 2/24/23, detailing the importance of recording any finings of damage to the facility home like environment in the maintenance logs. The Director of Maintenance will conduct a facility wide environmental audit of the remainder of the walls and bathroom floors by 2/24/2023 and a plan will be put	

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F 584	Continued From page 7 b. Room 201 bathroom floor with large brown stain around the commode and multiple other stained areas on the floor. c. Room206 bathroom floor discolored. d. Room207 bathroom floor with large brown stain around base of commode. d. At the end of the 300 hallway on the right side, the wallpaper was peeling off and scratches were observed on the walls. e. Room 301 bathroom floor with large stain around commode. f. Room 305 with scratches and large gouges in the wall behind the bed. g. Room 306 the bathroom linoleum around the toilet was lifted from the floor with a large crack. h. The hallway in front of the North Station nurses' station had deep scratches to the walls with damage to the wallpaper and dry wall. i. Room 605 bathroom floor with large dark stain around base of commode. j. Room 607 bathroom floor with dark stain around base of commode. k. Room 609 bathroom floor with discolored floor with dark stains around the commode. The wall in the bathroom had been patched but not sanded or painted. An interview and facility tour was conducted on 2/08/23 at 4:24 PM with the Director of	F 584	in place to make all necessary repairs. Administrator will choose one member of the administrative team to complete concierge rounds with each week for 12 weeks to ensure the ambassador round process is intact and the team members are identifying areas that need improvement. The Director of Maintenance and the Administrator will make facility rounds monthly for 3 months to ensure all areas of environmental concerns are identified and handled appropriately. Audits will be reviewed in Quality Assurance Performance Improvement meeting monthly for 3 months. The plan of correction may be modified or audits extended to ensure ongoing compliance.	

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F 584	Continued From page 8 Maintenance (DM). The DM stated he had been in the position since late October 2022 and the building needed a lot of attention. He explained there were no specific plans to replace the floors in the bathrooms or repair the damage to the walls in the resident rooms or hallways. DM stated he was in and out of resident rooms frequently but did not formally audit rooms for damage or maintenance needs. An interview and facility tour was conducted on 2/08/23 at 5:07 PM with the Administrator. The Administrator stated the resident rooms including the bathrooms and walls in rooms were in bad shape and needed to have work done on them. He explained that he and several other managers were new to their positions and there wasn't a plan yet to get the repairs made and he further explained it needed to be done. During an interview on 2/09/23 at 10:30 AM with the Housekeeping Supervisor revealed he had been in the position since early 2022 and had noticed the staining, discoloration, and damage to the bathroom floors, and they needed to be replaced. The Housekeeping Supervisor stated the condition of the resident rooms was discussed in management meetings but there was not a plan to replace the flooring that he was aware of. A follow up interview was conducted with the Administrator on 2/09/23 at 4:20 PM with the Administrator. The Administrator stated the resident rooms and common areas should be homelike, comfortable and in good repair.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/6/23

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F 641	Continued From page 9 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code pain assessments on the Minimum Data Set (MDS) quarterly assessments for 2 of 18 residents (Resident #30 and Resident #55) reviewed. Findings included: 1) Resident #30 was admitted to the facility on 12/31/15. Diagnoses included, in part, osteoarthritis, right and left above the knee amputations (AKA), and chronic pain. Review of the physician orders for Resident #30 revealed an order for Tylenol (pain reducing medication) 1000 milligrams (mg) by mouth two times daily for pain written on 01/26/18, and Morphine (narcotic pain-relieving medication) 15 mg 1 tablet by mouth three times a day for chronic pain written on 07/15/22. The MDS quarterly assessment dated 12/08/22 revealed Resident #30 was cognitively intact. He was coded as receiving scheduled pain medication on the assessment and the MDS indicated Resident #30 should be assessed for pain. The MDS indicated the resident was not interviewed to assess for frequency of pain, pain causing resident not to sleep, if pain was limiting resident's activities of daily living or a pain interview to determine the pain scale intensity. These assessments were all recorded as "not assessed." The MDS indicated Resident #30	F 641	Resident #55 has an MDS assessment scheduled for 03/06/2023 and Resident #30 had a quarterly assessment completed on 02/27/2023 that included the MDS pain assessment. On 02/13/2023 the MDS nurse audited all assessments scheduled after 11/1/2022 for current residents for MDS pain assessment accuracy and completion. One assessment was modified since the MDS pain assessment was completed but it was coded incorrectly. All other residents identified will be assessed with their next scheduled MDS. The Regional Reimbursement Nurse educated the facility MDS nurses by phone on 2/13/2023 and again in person on 2/15/2023 on the pain interview requirements and MDS coding accuracy. The Director of Nursing or designee will audit all MDS pain assessments 5x week for 12 weeks to ensure the assessment is completed and accurate. Any identified issue will be corrected before the MDS is submitted. Audits will be reviewed monthly in the Quality Assurance Performance Improvement meeting for 3 months. The plan of correction may be modified or the audits extended to ensure ongoing compliance.	

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F 641	Continued From page 10	F 641		

received 7 days of opioids (narcotic pain-relieving medication).

An interview was conducted with MDS Nurse #1 on 02/09/23 at 12:47 PM. MDS Nurse #1 stated the section that related to pain should have been assessed for Resident #30. She stated she did not know why it was not done accurately.

2) Resident #55 was admitted to the facility on 08/31/20. Diagnoses included, in part, gout, osteoarthritis, and low back pain.

The MDS quarterly assessment dated 01/02/23 revealed Resident #55 was cognitively intact. He was coded as receiving scheduled pain medication on this assessment and the MDS indicated Resident #55 should be assessed for pain. The MDS indicated the resident was not interviewed to assess for frequency of pain, pain causing resident not to sleep, if pain was limiting resident's activities of daily living or a pain interview to determine the pain scale intensity. These assessments were all recorded as "not assessed." Resident #55 received 7 days of opioids (narcotic pain-relieving medication).

An interview was conducted with Nurse #2 on 02/09/23 at 1:30 PM. Nurse #2 stated if a quarterly pain assessment had been done it would have pulled that assessment information into the MDS. She stated the pain assessment was not completed and therefore the MDS information was recorded as "not assessed." MDS Nurse #2 stated the pain assessment should have been completed and it was up to her and the nurses to complete the quarterly pain assessments so the MDS could be completed accurately.

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F 641	Continued From page 11 An interview was conducted with the Administrator on 02/09/23 at 5:48 PM. The Administrator stated he expected the MDS Coordinators to complete pain assessments quarterly and to maintain accurate MDS records to reflect the care provided to the residents.	F 641		
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 observations, record review, staff, Physician and Nurse Practitioner interviews the facility failed to discontinue an NPO (nothing by mouth) order and resume medications following notification of a cancelled procedure resulting in a resident missing two doses of an antiplatelet medication (Plavix) and not being served a breakfast meal for 1 of 1 resident reviewed. (Resident #66). Findings included. Resident #66 was admitted to the facility on 08/27/21 with diagnoses including bilateral kidney mass, benign prostatic hyperplasia (BPH-enlarged prostate) with urinary tract symptoms, urine retention, heart disease, peripheral artery	F 684	Nurse Practitioner was notified by the unit manager on 2/8/2023 that the appointment was cancelled for resident #66. Order was obtained from the provider to resume the Plavix and discontinue the NPO order. All appointments scheduled on or after 1/20/2023 were reviewed by the Unit Manager on 2/20/2023 to ensure no one had missed a schedule appointment and that the Provider was notified. There were two missed appointments identified for current residents that had not been reported to the Provider. The unit manager documented that the practitioner was notification in the Electronic Medical	3/6/23

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AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(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 684	Continued From page 12 disease, and diabetes. A care plan dated 07/22/22 for Resident #66 revealed he received blood thinning medications and to administer medications as prescribed. A care plan also revealed Resident #66 was at risk for nutritional decline due to multiple comorbidities and to provide diet per order. The Minimum Data Set (MDS) assessment dated 12/05/22 revealed Resident #66 was severely cognitively impaired and required extensive assistance with activities of daily living (ADLs). Record review revealed Resident #66 was scheduled for urology procedures for Cystolitholapaxy (surgical procedure to treat bladder stones) and for Transurethral resection of the prostate (TURP- surgical procedure to treat urinary problems caused by an enlarged prostate). The procedures were scheduled for 02/08/23 at 11:00 AM. A pre-surgical order dated 01/16/23 for Resident #66 was in place to remain NPO (nothing by mouth) after midnight the day before surgery on 02/08/2023. A pre-surgical order dated 01/16/23 for Resident #66 was in place to hold Plavix oral tablet 75 milligrams (antiplatelet) administered once a day for peripheral arterial disease from 02/02/23 through 02/08/23. A pre-surgical order dated 01/16/23 for Resident #66 was in place instructing that medications to take the morning of surgery with a sip of water included Seroquel (antipsychotic), Metoprolol (antihypertensive) and Flomax (alpha blocker for	F 684	Record for each resident on 2/20/2023. There were no new orders following the cancellations. The Director of Nursing or designee will educate the transportation staff on informing nurses when appointments are cancelled by 2/24/2023 and education will be provided to the nurses by the Director of Nursing or designee by 2/24/2023 on notifying the provider of appointment cancellations and reviewing orders related to the cancelled appointments. All appointments will be audited 5x week for 12 weeks to ensure each appointment is kept, any cancellations are reported to the Provider, orders have been reviewed and that documentation is accurate in the Electronic Medical Record. Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting for three months. Plan of correction may be modified, or audits extended to ensure ongoing compliance.	

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treatment of enlarged prostate) prior to surgery on 02/08/23.

Review of the Medication Administration Record dated February 2023 for Resident #66 revealed Plavix 75 milligrams was not administered from 02/02/23 through 02/08/23.

On 02/08/23 at 09:45 AM Resident #66 was observed sitting in his wheelchair in the hallway fully dressed and covered with a blanket.

During an interview with Nurse #1 on 02/08/23 at 09:45 AM she stated Resident #66 was waiting for an outside transport service to transport him to the surgical center for his scheduled procedure. She stated he had been NPO since midnight, his Plavix had been held for 7 days, he received the chlorhexidine bath earlier, and received his Seroquel, Metoprolol, and Flomax earlier that morning.

On 02/08/23 at 1:30 PM Resident #66 was observed in his room lying in bed. He was oriented to person only.

During an interview on 02/08/23 at 1:30 PM Nurse #1 stated when transport never showed up, she asked about it and was told by the facility transporter that the procedure was not scheduled for today. She stated the Nurse Practitioner was notified by the unit manager at that time and orders were received to resume medications for Resident #66. She stated Resident #66 did not get breakfast due to being NPO, but he was provided a lunch meal. She stated Resident #66 was oriented to person only and it was hard for him to make his needs known. She stated Resident #66 received a regular diet and ate

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100% of his lunch that was provided today.

An interview was conducted on 02/08/23 at 3:32 PM with the facility transporter. He stated on 01/16/23 he was notified by urology that the procedure for Resident #66 was scheduled for 02/08/23 at 11:00 AM at the hospital surgical pavilion and instructions were given to hold Plavix for 7 days and NPO after midnight prior to the procedure. He stated two days ago on 02/06/23 around 2:30 PM the urology office called the facility to schedule another appointment for Resident #66. He stated he informed urology that the resident had an appointment scheduled this week on 02/08/23 for a procedure at the surgical pavilion and urology informed the transporter at that time that Resident #66 did not have an appointment scheduled for 02/08/23 that the appointment was scheduled for 03/08/23. The facility transporter stated he notified the residents nurse (#10) on Monday 02/06/23 that the procedure would not be on 02/08/23. He stated he notified the unit manager the following day on 02/07/23 that the procedure was not going to be this week.

An interview was conducted on 02/08/23 at 4:08 PM with Nurse #10. She stated she was informed by the transporter that the procedure for Resident #66 was not scheduled this week but could not recall if it was Monday or Tuesday when she was notified. She stated she did not notify anyone and indicated she did not notify the provider on 02/06/23 to get orders to discontinue the NPO order and resume his medications. She stated she thought that was handled by someone else.

An interview was conducted on 02/08/23 at 4:36 PM with the unit manager. She stated the facility

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transporter did notify her late in the day on 02/07/23 but she thought the transporter meant that he was unsure whether or not the procedure was this week. She stated she misunderstood when he notified her and indicated she should have followed through with it and notified the physician to get orders to discontinue the NPO order and resume the medications for Resident #66.

An interview was conducted with the Physician on 02/09/23 at 11:30 AM. He stated he was not aware of the date of the scheduled procedure for Resident #66. He indicated if the procedure was not this week and orders were in place to have resident NPO and hold medications then the nurse should have notified him or the Nurse Practitioner on 02/06/23 to discontinue the NPO order and resume medications. He stated Resident #66 could have resumed medications on 02/06/23 but not receiving Plavix Monday through Wednesday had no significance and would not cause any harm or concern.

During an interview on 02/09/23 at 12:08 PM the Nurse Practitioner stated she was notified the afternoon of 02/08/23 of the mix up with the schedule for the procedure. She stated orders were given at that time to the unit manger to discontinue the NPO order and resume medications for Resident #66. She indicated if she had been notified on 02/06/23 that the procedure was not scheduled this week the Plavix would have resumed and Resident #66 would have received a dose on 02/07/23 and on 02/08/23. She indicated the NPO order would have been discontinued and Resident #66 would have been served breakfast.

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F 684	Continued From page 16 During an interview on 02/09/23 at 3:41 PM the Director of Nursing (DON) stated Nurse #10 should have notified the provider on 02/06/23 when the transporter told her that the appointment was not scheduled this week for Resident #66 and obtained orders to discontinue the NPO order and resume medications. She indicated if that had occurred Resident #66 would have recieved his breakfast the morning of 02/08/23 and would have started back on the Plavix sooner.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner interviews the facility failed to implement new wound treatments orders prescribed by the wound care physician for 1 of 3 residents (Resident #62) reviewed for wound care. Findings included.	F 686	Orders were entered into the electronic medical record for resident #62 by the unit manager on 2/8/2023. A skin assessment was completed by the floor staff on all residents on 2/8/2023 to identify any skin impairment. The skin assessments were reviewed by the Director of Nursing and the unit manager	3/6/23

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F 686	Continued From page 17 Resident #62 was admitted to the facility on 07/02/20 with diagnoses to include; glaucoma, diabetes, and was legally blind. A care plan dated 09/09/22 revealed Resident #62 had the potential for skin breakdown due to impaired mobility, and incontinence. The goal of care was to maintain skin integrity. Interventions included to complete skin assessments per protocol, provide diet as ordered, turn and reposition, and use a pressure relieving device to the bed. The Minimum Data Set (MDS) quarterly assessment dated 12/07/22 revealed Resident #62 had severely impaired cognition and required extensive assistance with activities of daily living (ADLs). He was at risk for the development of a pressure ulcer but had no pressure wounds at the time of assessment. A progress note dated 01/24/23 at 2:15 PM written by the Nurse Practitioner revealed; this clinician was notified and shown by the nurse aide of red/purple discoloring to the sacral area. The nurse and DON (Director of Nursing) were notified. They have contacted the wound care nurse for further evaluation and treatment. Recommendation were made to offload the sacral area when able. A skin/wound assessment dated 01/24/23 revealed Resident #62 with a deep tissue injury to the sacrum/coccyx measuring 5 centimeters (cm) x 6.5 cm x 0 depth. The area was in house acquired. The wound area was black with no odor. The pain level was zero. The Responsible Party (RP) was notified. The treatment was	F 686	to ensure each identified skin impairment had an appropriate treatment order in place. The wound care provider notes from 2/21/2023 were reviewed on 2/22/2023 by the unit manager to ensure all orders were transcribed and updated correctly. By 2/25/23 the Director of nursing or designee had educated all nurses on notifying the MD upon discovering a new wound to obtain treatment orders, entering orders into the electronic medical record and notifying the Director of Nursing and Unit Manager of new wounds. The Unit Manager / Wound Care Nurse was educated by the Regional Director of Clinical Services on reviewing the wound care providers orders and ensuring the orders are correct in the electronic medical record on 2/22/2023. The Director of Nursing or designee will perform 10 random skin assessments each week to ensure all skin areas are being treated and there is an order in the Electronic Treatment Record for each wound. The audits will be conducted for 12 weeks. Audits will be reviewed in the Quality Assurance Performance Improvement meeting for 3 months. The plan of correction may be modified or audits extended to ensure ongoing compliance.	

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barrier cream and to off load.

Review of the wound physician note dated 01/31/23 revealed a wound assessment of the sacrum that was in house acquired. The measurements were 7.0 cm x 7.0 cm x 0.3 cm, the wound was unstageable with 20% granulation, and 30% necrotic tissue with mild serous drainage. There were no signs of infection. The wound had opened areas with necrotic tissue. The treatment order was to cleanse with wound cleaner, and normal saline, pat dry, and apply Medi honey (aides and supports debridement and wound healing), and cover with a dry dressing daily.

Review of the most recent wound physician note dated 02/07/23 revealed a wound assessment of the sacrum. The wound measurements were recorded as 3.9 cm x 3.0 cm x 1.3 cm, with 30% granulation tissue, and mild serous drainage. The primary dressing was to apply Medi honey and a dry protective dressing daily and to continue the current treatment.

Review of the Treatment Administration Record (TAR) from 01/31/23 through 02/07/23 for Resident #62 revealed no daily dressing changes using Medi honey and normal saline were administered to the sacrum.

Review of the Medication Administration Record (MAR) from 01/31/23 through 02/07/23 for Resident #62 revealed no daily dressing changes using Medi honey and normal saline were administered to the sacrum.

An interview was conducted on 02/08/23 at 10:13 AM with Nurse #1. She stated Resident #62 did

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F 686	Continued From page 19	F 686		

not trigger for daily dressing changes to the sacrum. She stated she thought he received barrier cream only to the sacrum.

An interview was conducted on 02/08/23 at 12:00 PM with the unit manager. She stated Resident #62 developed a deep tissue injury to the sacrum that was first identified on 01/24/23. She stated they applied barrier cream to the area, and he was evaluated by the wound physician who came to the facility once a week.

During an interview with the Nurse Practitioner on 02/09/23 at 12:29 PM she stated she assessed Resident #62's wound on 1/24/23 and at the time the sacral wound was not opened and non-blanchable, and she wrote an order to off load the area. She stated Resident #62 was followed by the wound physician who came to the facility weekly for evaluations. She indicated according to the last measurements recorded on 02/07/23 the sacral wound was improving.

A follow up interview was conducted with the unit manager on 02/09/23 at 2:11 PM. She stated she rounded with the wound physician on 01/31/23 and she did not recall hearing him say to start daily dressing changes. She stated he may have told her that, but she did not hear it. She stated the wound physician submitted his evaluation report the following day and she was not used to his process and did not realize she needed to review his wound evaluation sheet that would list physician orders. She stated they had a wound nurse for many years who managed all wound care orders but recently retired and they were still trying to figure out the process to manage wound care. She stated she should have known to review the wound physicians progress report to

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F 686	Continued From page 20 check for wound status and to check for new orders and she did not do that. An interview was conducted on 02/09/23 at 3:00 PM with the Director of Nursing (DON). She stated the wound care nurse recently retired and currently the unit manager who was new to the process made rounds with the wound physician. She stated the unit manager should have reviewed the wound report submitted by the physician on 01/31/23 and implemented the new treatment order.	F 686		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced	F 757		3/6/23

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F 757	Continued From page 21 by: Based on record review, staff, Nurse Practitioner and Physician interviews the facility failed to hold a blood pressure medication as ordered by the physician for 1 of 5 residents (Resident #66) reviewed for unnecessary medications. Findings included. Resident #66 was admitted to the facility on 08/27/21 with diagnoses including hypertension, heart disease, and diabetes. A physician's order dated 08/11/22 for Resident #66 revealed to administer Metoprolol 25 milligram (mg) tablets two times a day for hypertension and hold for systolic blood pressure less than 100 mmHg (millimeters of mercury) or pulse less than 50 beats per minute. The Minimum Data Set (MDS) assessment dated 12/05/22 revealed Resident #66 was severely cognitively impaired and required extensive assistance with activities of daily living (ADLs). Review of the Medication Administration Record (MAR) for Resident #66 dated December 2022 revealed Metoprolol 25 mgs was scheduled for administration at 9:00 AM and 9:00 PM. The following blood pressure readings were recorded and the nurse signed off that the medication was administered: 12/20/22 blood pressure at 9:00 PM 96/64 12/21/22 blood pressure at 9:00 PM 98/64 12/25/22 blood pressure at 9:00 PM 29/62	F 757	The Nurse Practitioner was notified by the Regional Director of Clinical Services on 1/3/2023 that resident #66 was given a blood pressure medication outside of the ordered perimeters. No new orders were obtained. On 3/2/2023 the Regional Director of Clinical Services did a 30 day chart review for 15 of 15 residents receiving blood pressure medication with perimeters. Provider was notified of each incident and recorded in a progress note. The Director of Nursing or designee will educate all nurses on 2/24/2023 on following the MD order as it relates to medications that include perimeters. A list of all residents that receive blood pressure medication with perimeters will be used to audit the electronic medical record 5 days a week for 12 weeks to ensure the nurses are following the physicians order. Any issues identified will be reported to the provider and the nurse will receive re-education. The audits will be reviewed monthly in the facility Quality Assurance Performance Improvement meeting. The plan may be modified, or audits extended to ensure ongoing compliance.	

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12/26/22 blood pressure at 9:00 PM 96/54

During an interview on 02/09/23 at 10:32 AM with Nurse #1 she stated the three nurses that signed off that the Metoprolol medication was administered outside of parameters were no longer employed at the facility. She stated she worked the morning of 12/20/22 and 12/25/22 and was assigned to Resident #66. She stated Resident #66 was oriented to person only and typically wanted to stay in bed and would sleep a lot some days. She stated on 12/20/22 and 12/25/22 she did not recall him having abnormal behaviors or unusual weakness due to low blood pressure. She stated when she administered the medication at 9:00 AM on 12/20/22 and 9:00 AM on 12/25/22 the residents systolic blood pressure ranged from 110-116 and she administered the medication because he was not outside of the parameters at that time. She stated due to Resident #66 typically staying in bed a lot and sleeping a lot during the day at times she didn't recall thinking there was any change in his condition.

During an interview on 02/09/23 at 9:36 AM the Director of Nursing (DON) stated the three employees that administered Metoprolol outside of the parameters to Resident #66 on 12/20, 12/21, 12/25, and 12/26/23 at 9:00 PM were agency staff and were no longer employed at the facility.

During an interview with the Physician on 02/09/23 at 11:30 AM he stated he was not aware of Resident #66 receiving Metoprolol outside of parameters in December but stated staff would have notified the Nurse Practitioner. He stated Resident #66 should not have received the

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Metoprolol if the blood pressure was below 100 systolic. He indicated although the medication was signed off as administered it did not cause harm to the resident.

During an interview on 02/09/23 at 12:34 PM with the Nurse Practitioner she stated she evaluated Resident #66 on 01/03/23 and was not aware he received Metoprolol outside of parameters during the week of 12/20/22. She stated the evaluation on 01/03/23 focused on his urology concerns. She stated Resident #66 had orders in place to hold Metoprolol if systolic blood pressure was below 100. She indicated the blood pressure recording of 29/62 on 12/25/22 could not have been accurate and stated the medication should have been held on the days his systolic pressure was below 100. She also indicated staff should notify the provider of trends such as a week of low blood pressures so medications could be reviewed and dosing adjusted as needed. She stated on 01/03/23 his blood pressure was good at that time. She stated the blood pressure parameters in place should be followed.

During a follow up interview on 02/09/23 at 3:30 PM the DON stated Resident #66's Metoprolol should have been held when the systolic pressure was below 100.

During an interview with the Regional Corporate Nurse on 02/09/23 at 4:30 PM she stated on 01/03/23 she reviewed all residents who had medication parameters in place when she was at the facility for a compliance visit. She stated she notified the Physician Assistant (PA) who no longer worked with the facility on 01/03/23 of Resident #66's medication being administered outside of the parameters in December 2022.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 24 The PA asked her what the residents blood pressure was at that time and on that day it was within normal limits, he gave no further orders and to continue monitoring. She stated it was noted in the resident's progress note on 01/03/23.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to 1.) record an opened date on 2 of 8 insulin pens and an oral	F 761	On 2/6/2023 the Director of Nursing removed the undated and expired medications and discarded them. On	3/6/23

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F 761	Continued From page 25 inhaler, failed to secure and label loose pills, and failed to discard expired eye drops on 3 of 4 medication carts (400, 600, 700). 2.) keep unattended medications stored in a locked medication cart for 2 of 4 medication carts observed for medication storage. Findings included. 1. An observation of the 400-hall medication cart on 02/06/23 at 11:30 AM along with Nurse #6 revealed a Humalog insulin pen with 40 units used with no opened date. Loose pills observed in the drawer of the medication cart included: a round pink tablet imprinted with 043, a white round tablet imprinted with 3171, and a pink oval tablet imprinted with 894. Review of the manufacturer's instructions for Humalog insulin revealed to discard 28 days after opening. During an interview on 02/06/23 at 11:35 AM with Nurse #6 she stated she was not aware the insulin pen was not dated and indicated she did administer insulin to the resident it was prescribed for earlier today. She stated she was new to the facility and still getting used to procedures. She acknowledged the Humalog insulin pen was not dated and stated she failed to check for an opened date prior to administering the insulin and stated she was not aware of the loose pills in the drawer of the medication cart. An observation of the 600-hall medication cart conducted on 02/06/23 at 12:30 PM with Nurse #10 revealed two bottles of Latanoprost (prescribed for treatment of glaucoma and ocular	F 761	2/6/2023 the medication carts were locked by the nurses once it was brought to her attention. The pharmacist from Omnicare inspected each medication cart on 2/6/2023 and removed all medications that were expired or undated after they were opened. Each cart lock was checked by the unit manager to ensure they were functioning properly on 2/22/2023. No issues with cart locks identified. Education will be provided to the nurses by the Director of Nursing or designee by 2/24/2023 on Medication Storage, drug labeling and ensuring med carts are locked at all times when not in direct view of the nurse. The Director of Nursing or designee will conduct medication cart audits for each cart weekly for 12 weeks to ensure medications are labeled and stored appropriately and that staff are locking the carts when not in use. All issues identified will be corrected and re-education will be provided to the nurse. Audits will be reviewed in the Quality Assurance Performance Improvement meeting for 3 months. The plan of correction may be modified or audits extended to ensure ongoing compliance.	

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hypertension) ophthalmic solution. Bottle #1 had an opened date of 12/13/22 and bottle #2 with an opened date of 12/20/22.

Review of the manufacturer's instructions for Latanoprost revealed once a bottle is opened for use it may be stored at room temperature for up to six weeks.

During an interview on 02/06/23 at 12:30 PM with Nurse #10 she stated she was not aware the Latanoprost eye drops had a shortened expiration date, and she did not realize they were expired. She stated she had not administered the eye drops to the resident they were prescribed for.

An observation of the 700-hall medication cart on 02/06/23 at 1:00 PM along with Nurse #9 revealed a Novolog insulin pen with no opened date with a small amount of insulin remaining in the pen and a Serevent Diskus oral inhaler that was not labeled or dated.

Review of the manufacturer's instructions revealed to discard Novolog insulin pen 28 days after opening. The manufacturers instructions for the Serevent Diskus oral inhaler revealed the medication should be stored inside the unopened moisture protective foil pouch and only removed from the foil pouch immediately before initial use. Discard Serevent Diskus 6 weeks after opening the foil pouch.

During an interview on 02/06/23 at 1:00 PM with Nurse #9 she stated she was not aware the Novolog was not dated but acknowledged it had been used. She stated the Serevent inhaler should be labeled and dated, and it was not. She stated the nurses usually checked the carts to

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look for expired medications and to make sure medications were labeled and dated. She indicated the insulin should have been discarded by the expiration date and stated she had not administered the insulin and did not check it.

An interview was conducted on 02/09/23 at 3:00 PM with the Director of Nursing. She stated insulin and the Serevent oral inhaler should be labeled and dated when opened. She stated the expired medications should be removed by the nurse on the medication cart and indicated the nurses routinely checked the medication carts for expired medications and to ensure medications were labeled and dated. She stated she expected expired medications to be discarded by the expiration date and medications to be labeled and dated when opened.

2) An observation of a medication cart stored on the 700 hall was noted to be unlocked and unattended on 02/26/23 at 10:08 AM. The medication cart was noted to be facing the hallway where 3 alert residents propelling themselves in wheelchairs were noted to be passing by the unsecured medication cart. The cart was left unattended and unlocked for 3 minutes.

An interview was conducted with Nurse #9 on 02/06/23 at 10:11 AM. Nurse #9 stated she would not normally leave the medication cart unlocked and had forgotten to lock it before she walked away from it. Nurse #9 stated it was important to make sure the medication carts were secured at all times when they were unattended for the safety of the residents.

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F 761	Continued From page 28 An interview was conducted with the Regional Clinical Director on 02/09/23 at 5:00 PM. The Regional Clinical Director stated she expected her nursing staff to ensure they were securing the medication carts at all times when unattended. 3). During an observation on 2/6/23 at 3:10 PM the 400 hall medication cart was observed unlocked and unattended facing the hallway on the 400 hall. The locking mechanism was popped out which indicated the cart was unlocked. At 3:15 PM several staff members were observed walking past the unlocked, unattended medication cart. At 3:20 PM, Nurse #6 was observed as she opened the medication cart, retrieved the narcotic inventory sign out book from the bottom dry and proceeded to sign out a medication. During an interview on 2/6/23 at 3:25 PM Nurse #6 confirmed she was assigned to the 400 hall medication cart for the 7 AM-7 PM shift on 2/6/23. Nurse #6 confirmed the medication cart was to be locked when it was unattended and it was her responsibility to lock and secure the cart. An interview was conducted with the Regional Clinical Director on 02/09/23 at 5:00 PM. The Regional Clinical Director stated she expected the nursing staff to ensure they were securing the medication carts at all times when unattended.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		3/6/23

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F 806	Continued From page 29 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to honor food preferences for 1 of 2 residents (Resident #36) reviewed for food preferences. Findings included. Resident #36 was admitted to the facility on 11/17/20 with diagnoses to include; cerebral vascular accident (CVA), congestive heart failure, and diabetes. A physician order dated 11/10/22 revealed Resident #36 had an order to receive a regular double protein diet, with regular texture, and thin consistency. A care plan dated 11/23/22 revealed Resident #36 was at risk for nutritional decline, dehydration, and weight fluctuations related to CVA, diabetes, and the need for a therapeutic diet, diuretic use, and variable oral intake. The goal of care was to be free of symptoms of dehydration, fluid overload, and electrolyte imbalance through the next review. Interventions included; to monitor dietary intake, monitor for signs and symptoms of dehydration, monitor weight, and provide diet per order.	F 806	The nurse for resident #36 removed the grits from her breakfast plate and provided the resident with eggs from the kitchen on 2/9/2023. A new food preference was completed by 3/2/2023 by the Dietary manager or designee. The preferences for each resident in the facility will be re-evaluated and update in the tray card system by the Dietary Manager or designee by 3/6/2023. Education was provided to the dietary staff by the Dietary Manager or designee by 3/01/2023 regarding the importance of honoring resident dislikes as listed on the tray cards. The dietary manager or designee will audit 10 resident meal trays weekly for 12 weeks to ensure resident dislikes are being honored based on the tray cards. The dietary manger or designee will also interview 5 residents each week to ensure their food preferences are being met. Any issues identified during the audits will be corrected. Audits will be reviewed during the Quality Assurance Performance Improvement meeting monthly for 3	

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The Minimum Data Set (MDS) quarterly assessment dated 01/05/23 revealed Resident #36 was cognitively intact. She required extensive assistance with activities of daily living and was independent with eating. She received a therapeutic diet and had no weight loss or gain.

An interview was conducted on 02/09/23 at 1:30 PM with Resident #36. She stated she was unhappy because she was served grits for breakfast this morning and she did not get eggs on her meal tray. She stated grits were on her dislike list on the meal ticket and the meal ticket also showed her preference included to have 2 pieces of bacon and eggs for breakfast every morning. She stated it was not the first time that she had not received her food preferences that were listed on her meal ticket.

An interview was conducted on 02/09/23 at 2:00 PM with Nurse #1. She stated Resident #36 was upset this morning because she was served pancakes and grits. She stated Resident #36 was ordered a regular diet, but she was diabetic and will refuse to eat carbohydrates. She stated Resident #36 was served grits on her breakfast tray, so she went to the kitchen and got her eggs and threw out the grits.

An interview was conducted on 02/09/23 at 3:09 PM with the Dietary Manager. She stated she spoke with Resident #36 last week and updated her meal preferences. She stated she didn't realize grits were placed on her breakfast tray this morning and didn't know she didn't get her eggs until the nurse aide notified her that she needed eggs for the resident. She stated there was a new kitchen staff member who didn't follow the

months. The plan of correction may be modified or audits extended to ensure ongoing compliance.

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F 806	Continued From page 31 resident's meal ticket which showed that the resident was to receive eggs for breakfast daily and disliked grits. She stated education would be provided. During an interview on 02/09/23 at 4:00 PM with the Director of Nursing she stated Resident #36's meal preferences should be honored, and the resident should not have been served food on her dislike list.	F 806		
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 record review, observations and staff interviews the facility failed to remove expired food items stored for use and failed to label and date leftover food for 2 of 3 nourishment rooms	F 812	F812 Food Procurement Expired food items were removed from the nourishment room refrigerators by the Dietary Manager on 2/9/2023.	3/6/23

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F 812	Continued From page 32 (South Station and 400 Hall nourishment rooms). This practice had the potential to affect the food served to the residents. The findings included: Interview on 2/07/23 1:46 PM with Nurse #7 revealed that when family brought in items for a resident they were to be labelled and dated before they were placed in the nourishment room refrigerator. Nurse # 7 stated after a few days, although she was not sure how many days exactly, the items were to be thrown away. Nurse # 7 further stated she was not sure who was responsible for discarding the expired food items from the nourishment room refrigerator. Interview on 2/7/23 at 1:50 PM with nursing assistant (NA)#2 revealed when a family brought in food for a resident the nursing staff labelled and dated it before putting it in the nourishment room refrigerator. NA #2 stated she thought food items could stay in the refrigerator 5-10 days before they were thrown away. NA#2 further stated she was not exactly sure how long food was stored in the refrigerator. NA #2 stated dietary discarded foods that were expired and was responsible for cleaning out the nourishment room refrigerator Observation of the South Station nourishment room on 2/7/23 at 1:56 PM revealed the following: " Open bottle of soda with no date. " Open bottle of electrolyte solution labelled with room number 715 and date of 1/2/23. " Open jar of Brussel sprouts labelled with the date 6/28. " Open bottle of Asian Roasted Sesame salad	F 812	All resident nourishment refrigerators will be audited by the Dietary Manager or designee by 2/24/2023. All expired or undated open items will be removed from the refrigerator and discarded. Education will be provided to the Dietary Manager by the Administrator by 2/24/2023 on ensuring the refrigerators are checked daily for expired or open undated items. Education will be provided to all staff by 2/27/2023 on labeling and dating resident food items prior to placing them into the nourishment refrigerators. The Dietary Manager or designee will audit each nourishment refrigerator 5x week for 12 weeks to ensure there are no undated opened or expired food items in the nourishment refrigerators. All items identified will be discarded. Audits will be reviewed for 3 months in the Quality Assurance Performance Improvement meeting. The plan of correction may be modified or audits extended to ensure ongoing compliance.	

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dressing labelled with a date of 4/7/22.
" Open jar of mayonnaise with no name or date. Expiration date printed on the jar by the manufacturer indicated 10/3/22.
" Open bottle of flavored coffee creamer labelled with the room number 508 and no opened date.
" Opened jar of kosher pickles labelled with a date of 3/28/22.
" Open bottle of Catalina salad dressing with no open date. Expiration date printed on the bottle by the manufacturer indicated October 14, 2022.

Observation on 2/07/23 at 2:28 PM on 400 Hall Nourishment Room refrigerator revealed the following:

" Open tray of deli sandwiches with no date or name.
" Styrofoam to go container of fried chicken tenders with no name or date.
" Plastic container of creamy lobster bisque dated 1/15/23. Expiration date printed on the container by the manufacturer was 2/5/23.
" Plastic to go container with obviously expired taco salad with no name or date.
" Styrofoam cup with a fast-food milk shake with no name or date.
" Open container with sherbet with no name or date.
" Styrofoam container with ice cream labelled with room number 402 and date 1/29.

Sign posted on 400 Hall Nourishment Room refrigerator indicated all food must be labeled and dated and anything that was not labeled or dated would be thrown away. The sign further stated anything older than 3 days would be discarded.

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Interview on 2/07/23 at 2:37 PM with Nurse #6 indicated when food was brought in by family or visitors it was to be labelled and dated prior to placing it in the nourishment room refrigerator. Nurse # 6 further stated she thought housekeeping cleaned out the refrigerators, but she was not sure. She stated she thought food stayed in the refrigerator for 7 days before it was discarded but stated she was not sure.

Interview on 2/7/23 at 4:31 PM with the Dietary Manager (DM) revealed that the nourishment rooms were checked daily by the dietary staff. DM stated if an item was not labeled or dated dietary staff were instructed to discard it.

Observation with the DM on 2/7/23 at 4:35 PM of the South Side nourishment room refrigerator revealed the previously observed expired items remained in the refrigerator including the opened bottle of soda with no date, the electrolyte solution with expired date, the expired mayonnaise, salad dressings, jar of Brussel sprouts, the coffee creamer with no opened date, and the kosher pickles with the expired date. DM stated she did not know how these items had been overlooked. Informed DM that there were expired and not labelled and dated items in the 400 hall nourishment room refrigerator as well. DM stated that it was important to check the dates and make sure there were not expired items. DM stated that it was important to resident safety that they not receive expired items. DM stated she did not know why the expired food items were in the nourishment room refrigerator and that they should have been discarded.

Interview on 2/09/23 at 4:20 PM with the

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F 812	Continued From page 35 Administrator revealed that he expected that the nourishment room refrigerators would be free from expired foods. The Administrator further stated that he expected that all out of date items would be discarded immediately.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		3/6/23

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§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,

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resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on

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F 867	Continued From page 38 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a recertification survey on 1/4/22, a complaint investigation on 7/29/22, a focused infection control survey on 2/17/21 and a recertification survey on 3/5/20. This was for 4 deficiencies that were originally cited in the areas of notification of changes, quality of care, label/store drugs and biologicals and food storage and were subsequently recited on the current recertification and complaint investigation on 2/9/23. The continued failure during five federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: F580 Based on observations, record review, staff, Physician and Nurse Practitioner interviews the facility failed to notify the Physician or Nurse Practitioner to discontinue an NPO (nothing by mouth) order and to resume medications following notification that a surgical procedure had been rescheduled for a later date for 1 of 1 resident reviewed. (Resident #66). During the complaint survey of 7/29/22, the facility failed to notify the physician when a medication was not administered due to medication was unavailable for 1 of 1 resident reviewed for notification. During the 1/4/22 recertification survey, the facility failed to notify the resident's provider when the	F 867	(F580) and (F684) The nurse practitioner was notified by the unit manager on 2/8/2023 that the appointment was cancelled for resident #66. Order was obtained from the provider to resume the Plavix and discontinue the NPO order. (F761) On 2/6/023 the Director of Nursing removed the undated and expired medications and discarded them. On 2/6/2023 the medication carts were locked by the nurse once it was brought to her attention. (F812) Expired food items were removed from the nourishment room refrigerators by the Dietary Manager on 2/9/2023. (F580) and (F684) All appointments scheduled on or after 1/20/2023 were reviewed by the Unit Manager on 2/20/2023 to ensure no one had missed a schedule appointment and that the Provider was notified. There were two missed appointments identified for current residents that had not been reported to the Provider. The unit manager documented the practitioner notification in the Electronic Medical Record for each resident on 2/20/2023. (F761) The pharmacist from Omnicare inspected each medication cart on 2/6/2023 and removed all medications that were expired or undated after they were opened. Each cart lock was checked by the unit manager to ensure they were functioning properly on 2/22/2023. No issues with cart locks identified. (812) All resident	

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F 867	Continued From page 39 resident presented with signs and symptoms of a change in condition following an unwitnessed fall for 1 of 2 residents reviewed for notification and failed to notify the provider of a delay in receiving an ordered medication. During the focused infection control survey of 2/17/21, the facility failed to notify the responsible party of a change in condition related to a new diagnosis, order for a new medication and the need for continuation of transmission based precautions for a new infection for 1 of 2 residents reviewed for notification. F684 Based on observations, record review, staff, Physician and Nurse Practitioner interviews the facility failed to provide two doses of an antiplatelet medication (Plavix) unnecessarily and failed to provide a breakfast meal on the morning of a surgical procedure that was known to have been rescheduled for a later date for 1 of 1 resident reviewed. (Resident #66). During the complaint survey of 7/29/22, the facility failed to review the hospital discharge summary resulting in the failure to transcribe and administer two ordered medications for 1 of 3 residents reviewed for medication administration. F761 Based on observations, record review, and staff interviews the facility failed to 1.) record an opened date on 2 of 8 insulin pens and an oral inhaler, failed to secure and label loose pills, and failed to discard expired eye drops on 3 of 4 medication carts (400, 600, 700). 2.) keep unattended medications stored in a locked medication cart for 2 of 4 medication carts observed for medication storage. During the recertification survey of 3/5/20 the facility failed to remove expired medications, failed to record an opened date for an oral	F 867	nourishment refrigerators will be audited by the Dietary Manager or designee by 2/24/2023. All expired or undated open items will be removed from the refrigerator and discarded. The facility administrator was educated by the Regional Director of Clinical Services on 2/24/2023 on Quality Assurance Performance Improvement program, Quality Assurance Fundamentals and the corrective actions for citations F580, F684, F761 and F812. To monitor ongoing Quality Assurance Performance Improvement, the Regional Director of Clinical Services or the Regional Director of Operations will be attend the monthly Quality Assurance Performance Improvement meeting to assure pertinent items are included and worked on monthly for 3 months.	

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inhaler, and failed to refrigerate a liquid medication that required refrigeration upon opening for 1 of 4 medication carts and failed to discard an expired topical medication.

F812 Based on record review, observations and staff interviews the facility failed to remove expired food items stored for use and failed to label and date leftover food for 2 of 3 nourishment rooms (South Station and 400 Hall nourishment rooms). This practice had the potential to affect the food served to the residents.

During the recertification survey of 3/5/20, the facility failed to label and date items in the dry storage area, walk in refrigerator and freezer and failed to discard expired items from these areas.

Interview on 2/9/23 at 4:20 PM with the Administrator revealed he did not know why the QAPI plan was not effective. He had been at the facility since August 2022 and felt that the areas that were recited had been looked at, but the facility may require a more systematic approach and that monitoring may have stopped too soon. The Administrator stated improvements were needed in the clinical morning meeting to be sure that notifications occurred, and other areas were addressed regularly. He stated the Director of Nursing (DON) was new to her position at the facility. Administrator further stated the facility needed to improve systems currently in place and determine the reason the previous systems did not work.