STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/6/23 through 3/10/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 543E11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted on 3/6/23 through 3/10/23. Event ID # 543E11. The following intakes were investigated NC00199022, NC00199038 and NC00194257. 1 of the 10 complaint allegations resulted in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 staff interviews and record reviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for the following areas: Activities of Daily Living (Resident #25); mood (Resident #25 and Resident #49) and cognition (Resident #49). This occurred for 2 of 33 residents reviewed for MDS accuracy. The findings included: 1-a. Resident #25 was admitted to the facility on 8/25/21. The resident's 8/25/21 hospital discharge summary indicated a percutaneous endoscopic gastrostomy (PEG) tube was placed	F 641	F641 Accuracy of Assessments The identified residents with errors, #25 and 49 have a new assessment completed related to their mood and cognition assessments/interviews. The feeding coding error assessment was re-submitted on 3/9/23. All residents have the potential to be affected. The Regional MDS nurse/designee will audit the assessments completed for the last 30 days from 3/27/23 to include eating, cognition and mood coding assessment accuracy on or	4/5/23

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

Electronically Signed | 03/28/2023

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F 641	Continued From page 1 due to his diagnosis of dysphagia (difficulty swallowing). A PEG tube is a feeding tube inserted through the skin and the stomach wall to provide nutrition. The resident received nothing by mouth (NPO). Resident #25's physician orders included Osmolite 1.5 (a liquid formulation used to provide sole-source nutrition via a tube feeding) to be administered as a continuous feeding via PEG tube at 50 milliliters (ml) per hour for 24 hours each day (Start Date 12/24/22). The resident was NPO. Review of the resident's electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) assessment was dated 12/27/22. The MDS reported Resident #25 received nutrition via a feeding tube. His assessment of functional status indicated the resident was totally dependent on staff for all of his Activities of Daily Living (ADLs) with the exception of requiring only limited assistance from staff for eating. An interview was conducted on 3/9/23 at 10:13 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses were asked to review the ADL section from Resident #25's quarterly MDS assessment dated 12/27/22. Upon review, MDS Nurse #1 confirmed the resident's MDS indicated he received only limited assistance with eating. However, MDS Nurse #1 stated the MDS should have indicated Resident #25 was totally dependent on staff for eating since the tube feeding was his sole source of nutrition. MDS Nurse #2 reported a correction needed to be submitted for this 12/27/22 quarterly MDS.	F 641	before 4/5/23. Education completed by Administrator/designee for MDS staff and Social services staff on assessment accuracy on or before 4/5/23. The Regional MDS nurse/designee will complete 5 random MDS audits for coding accuracy x4 weeks to begin 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Administrator will be responsible for implementation of the plan.	

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F 641	Continued From page 2	F 641		

An interview was conducted on 3/9/23 at 11:12 AM with the facility's Director of Nursing (DON). During the interview, concerns regarding the inaccuracy of Resident #25's MDS was discussed. When asked, the DON reported she would expect the MDS assessments to be completed accurately.

1-b. Resident #25 was admitted to the facility on 8/25/21. His cumulative diagnoses included dysphagia (difficulty swallowing) and placement of a percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube inserted through the skin and the stomach wall to provide nutrition).

Review of the resident's electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) assessment was dated 12/27/22. The MDS reported Resident #25 was rarely/never understood and he rarely/never understood others. The resident's cognition was assessed by staff to be severely impaired. The MDS assessment instructions indicated that if the resident was rarely/never understood, a staff assessment of resident mood should be completed. However, Resident's #25's MDS reported his mood was assessed by a "Resident Mood Interview" instead of a staff assessment.

An interview was conducted on 3/9/23 at 10:13 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses were asked to review the Mood section from Resident #25's quarterly MDS assessment dated 12/27/22. Upon review, MDS Nurse #2 reported if a resident was not able to be interviewed, a staff assessment would be indicated for completion of the Mood assessment. The MDS Nurses stated the facility's Social Worker was typically

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F 641	Continued From page 3	F 641		

responsible to complete the "Mood" section of the MDS assessment.

An interview was conducted on 3/9/23 at 10:41 AM with the facility's Social Worker. During the interview, the Social Worker reviewed the Mood section from Resident #25's MDS assessment dated 12/27/22. The Social Worker reported the information in the Mood section was incorrect and a staff assessment should have been completed.

An interview was conducted on 3/9/23 at 11:12 AM with the facility's Director of Nursing (DON). During the interview, concerns regarding the inaccuracy of Resident #25's MDS was discussed. When asked, the DON reported she would expect the MDS assessments to be completed accurately.

2. Resident #49 was readmitted to the facility on 01/17/23.

Resident #49's quarterly Minimum Data Set (MDS) dated 01/23/23 revealed she had clear speech, was understood, and could understand. A Pain Assessment Interview was conducted and noted Resident #49 had no report of pain. The resident Brief Interview for Mental Status (BIMS) cognition assessment contained dashes (-) indicating the items were not assessed. The Staff Assessment for Mental Status indicated Resident #49 was unable to complete the BIMS assessment, had no memory problems and was independent with decision making. The Resident Mood Interview contained dashes (-) indicating the items were not assessed. The Staff Assessment for Resident Mood was conducted and did not indicate Resident #49 had any moods

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F 641	Continued From page 4 present. The MDS indicated Resident #49 had participated in the assessment. An interview was conducted on 3/9/22 at 1:30 pm with MDS Coordinator #1. He indicated Resident #49 was alert and able to conduct the cognition and mood assessments for the MDS. He stated the Social Worker was responsible for the cognition and mood assessments and he did not know why the staff assessment was conducted. During an interview with Social Worker #2 on 03/09/23 at 2:32 pm she stated the cognition and mood assessments were coded in error. She indicated Resident #49 was alert and oriented and should have been assessed, instead of conducting the staff assessment. During an interview with the Administrator on 03/09/23 she stated she would expect the MDS assessments to be completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/5/23

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F 656	Continued From page 5 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to ensure a resident's comprehensive care plan reflected the interventions implemented for positioning and falls for 1 of 33 residents whose care plans were reviewed (Resident #132).	F 656	F656 Develop/Implement Comprehensive Care Plan The identified resident #132 was noted that the facility failed to ensure a resident comprehensive care plan reflected the interventions implemented for positioning	

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F 656	Continued From page 6 The findings included: 1-a. Resident #132 was admitted to the facility on 7/30/21. His cumulative diagnoses included a developmental disorder and non-Alzheimer's disease. A quarterly Minimum Data Set (MDS) assessment dated 1/17/23 indicated Resident #132 had severely impaired cognition. He required extensive assistance from staff for all of his Activities of Daily Living (ADLs) with the exception of being totally dependent on staff for toileting. The resident was reported to have one-Stage 3 pressure ulcer. Resident #132's care plan addressed the following area of focus, in part: --The resident is at risk for skin breakdown related to impaired mobility. Resident #132 was noted to have actual skin integrity impairment with a Stage 3 pressure ulcer on his sacrum (Date Initiated: 11/18/22; Revision on: 3/8/23). The interventions included the use of positioning pillows while in bed (Date Initiated 8/19/22). The care plan did not include the use of a perimeter bed or positioning wedge. An observation was conducted on 3/6/23 at 11:47 AM of Resident #132's room. The resident's bed was observed to have a perimeter mattress (a mattress designed with the height of its edges greater than the center) in place with a positioning wedge on the left side near the head of the bed. Another observation was made on 3/7/23 at 9:19 AM as Resident #132 was observed to be lying in bed. His bed had a perimeter mattress in place with a wedge placed on the upper left side of his bed.	F 656	and falls as evidenced by failure to include the perimeter mattress, floor matt and positioning wedge on the care plan interventions, Resident # 132 care plan was immediately reviewed and updated to ensure accuracy of positioning and fall interventions. All residents that are at risk for falls and with a history of falls have potential to be affected. The Director of Nursing, Assistant Director of Nursing/ Unit Manager will complete a whole house audit of falls and positioning devices, room to care plan audit of all current residents to ensure needed fall and positioning devices are present/still in use. Care plan audit will be initiated 3/27/23 and will be completed by 4/5/23 to protect residents in similar situations. Education was provided on 3/27/23 to the Unit Manager's/Clinical management team by the DON and MDS director on developing and implementing comprehensive care plans to match interventions in place. The DON/designee will complete 5 random care plan audits to ensure newly implemented positioning devices/fall interventions are in place weekly x4 weeks for accuracy of each audited resident's comprehensive care plan. Then bi-weekly x2 weeks, then monthly x1 month. The DON/designee will review care planned interventions as part of the	

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F 656	Continued From page 7 An observation of the resident's wound care was conducted on 3/8/23 at 9:35 AM as he was lying in his bed. During this observation, the resident was observed to have a perimeter mattress and a positioning wedge placed on the left upper side of the bed to aide in offloading and pressure reduction to his sacrum. Resident #132 was observed as being able to help turn himself when the nurse repositioned him for wound care. An interview was conducted on 3/9/23 at 4:15 PM with Nurse #1. Upon inquiry, the nurse confirmed Resident #132's perimeter mattress and wedge were utilized to assist with positioning due to his sacral pressure ulcer. An interview was conducted on 3/9/23 at 2:00 PM with the facility's Administrator and Director of Nursing (DON). Upon inquiry, the DON reported use of a perimeter mattress and positioning wedge should have been included in Resident #132's care plan. A follow-up interview was conducted on 3/9/23 at 2:30 PM with the facility's DON. During the interview, the DON confirmed the perimeter mattress and positioning wedge placed on Resident #132's bed were not care planned. Upon further inquiry, the DON stated the perimeter mattress was "not restrictive." However, she reiterated it should have been on the resident's comprehensive care plan. Another interview was conducted on 3/9/23 at 3:06 PM with the DON. At that time, the DON was asked who assumed responsibility to make revisions on residents' care plans. The DON reported, "It depends what it is" and stated making revisions to a resident's care plan was a team effort. She	F 656	clinical meeting to monitor the center's compliance and performance for sustained compliance with Comprehensive Care planning needs related to interventions. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for implementation of the plan.	

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F 656	Continued From page 8	F 656		

also reported the interventions implemented would have been based on the Interdisciplinary Team's (IDT's) input. It would have been the nurse's responsibility to include the interventions on the resident's care plan.

1-b. Resident #132 was admitted to the facility on 7/30/21. His cumulative diagnoses included a developmental disorder and non-Alzheimer's disease.

A quarterly Minimum Data Set (MDS) assessment dated 1/17/23 indicated Resident #132 had severely impaired cognition. He required extensive assistance from staff for all of his Activities of Daily Living (ADLs) with the exception of being totally dependent on staff for toileting.

Resident #132's care plan addressed the following areas of focus, in part:
--The resident is at risk for falls related to impaired mobility (Date Initiated: 7/31/21; Revision on: 1/30/23). The planned interventions did not include the use of a fall mat placed on the floor next to his bed.

An observation was conducted on 3/6/23 at 11:47 AM of Resident #132's room. A fall mat was observed to be placed on the left side of his bed. On 3/7/23 at 9:19 AM, Resident #132 was observed to be lying in bed. The fall mat was placed on the floor on the left side of his bed.

During an interview conducted on 3/9/23 at 2:30 PM with the facility's Director of Nursing (DON), the DON recalled Resident #132's fall mat was initiated as a fall intervention from a previous fall several months ago. Upon review of the

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F 656	Continued From page 9 resident's care plan, the DON confirmed the fall mat was not included in his comprehensive care plan. However, she reported this intervention should have been care planned. A follow-up interview was conducted on 3/9/23 at 3:06 PM with the DON. At this time, the DON was asked who assumed responsibility to make revisions on residents' care plans. The DON reported this was a team effort. The DON also stated that she would typically take the lead to put fall interventions into the resident's comprehensive care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, pharmacist, and Medical Director interviews, the facility failed to administer medications separately and flush the tubing between each medication administered to a resident via a feeding tube for a resident that did not have a physician's order specifying a different flush schedule because of a fluid restriction. This occurred for 1 of 1 resident observed to receive medications through a feeding tube (Resident #25). The findings included: Resident #25 was admitted to the facility on	F 658	F658 Professional Standards The identified resident #25 was noted the facility failed to administer medications separately and flush the tubing between each medication administered to the resident #25 via a feeding tube for a resident that did not have a physician's order specifying a different flush schedule because of a fluid restriction. One on one education was completed 3/27/23 with the identified nurse #7 on enteral medication administration to include flushing the enteral tube between medication administrations by the nurse practice	4/5/23

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F 658	Continued From page 10 8/25/21. The resident's 8/25/21 hospital discharge summary indicated a gastrostomy tube was placed due to his diagnosis of dysphagia (difficulty swallowing). A gastrostomy tube is a feeding tube inserted into the stomach to provide nutrition and a route for medication administration. The resident received nothing by mouth (NPO). Upon initiating the medication administration observation for Resident #25 on 3/8/23 at 9:28 AM, Nurse #7 reported a provider's order had been received which indicated all of the resident's medications could be crushed and administered together (cocktailed) via his gastrostomy tube. Nurse #7 was then observed as she placed 3 tablets into one medication cup in preparation for the med administration. These medications included: one tablet of 10 milligrams (mg) baclofen (a muscle relaxant); one tablet of 1000 Units cholecalciferol (a Vitamin D supplement); and one tablet of 20 mg famotidine (a medication to decrease gastric acid production). The nurse then poured 15 milliliters (ml) of a liquid multivitamin/mineral solution into a separate medication cup. On 3/8/23 at 9:32 AM, the nurse was observed as she placed the 3 tablets into a single plastic pouch, crushed the tablets together, then poured the crushed tablets back into a small medication cup. After entering Resident #25's room for the med administration, the nurse was observed as she flushed the resident's gastrostomy tubing with approximately 50 ml of plain water. Nurse #7 then poured approximately 10 ml of water into the small med cup containing the 3 crushed tablets and poured the crushed tablets mixed with water into the syringe. The nurse then added 5-10 ml water into the med cup three more times as she attempted to dissolve	F 658	educator. All residents with peg tube orders were reviewed and ordered to “cocktail” removed if fluid restrictions or inability to tolerate free water flushes were not indicated by the Unit Managers on 3/9/2023. Education and competency check offs were initiated by Director of Nursing /Nurse Practice Educator/pharmacy or designee on medication administration: enteral on 3/27/23 and to be completed by 4/5/23. All newly hired and contracted staff will have medication administration: enteral competency check offs completed by the Nurse Practice Educator, Director of Nursing, Unit Managers/designee. Director of Nursing/ Nurse Practice Educator/ Unit Managers will conduct random medication administration audits to include enteral delivery weekly x4 weeks. Then bi-weekly x2 weeks, then monthly x1 month. These audits will include weekend and “off shifts” as needed. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for	

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F 658	Continued From page 11 the remaining particles of the crushed tablets in the medication cup and instilled the medication solution into the syringe and tubing. After the crushed tablets mixed with water were administered to the resident, Nurse #7 poured the vitamin/mineral solution into the syringe for administration. No water flush was used between administering the crushed medications mixed in water and the vitamin/mineral liquid medication. Upon conclusion of the medication administration, the nurse flushed the tubing with plain water. The resident did not appear to have any discomfort with this flush. A review of Resident #25's current physician orders was conducted. These orders included the following, in part: --Enteral Feed: Flush tube with 15 ml of water before each medication pass every shift. Flush tube with at least 15 ml of water between each medication (Start Date 12/24/22). --All crushed meds may be administered together (cocktailed) for this resident due to the resident being NPO (Start Date 3/7/23). Further review of Resident #25's medical record revealed there was no documentation to indicate the resident was on a fluid-restriction or that he had difficulty tolerating free water flushes provided via his gastrostomy tube. An interview was conducted with Nurse #7 on 3/8/23 at 11:30 AM regarding the administration of Resident #25's medications via his gastrostomy tube. During the discussion, the nurse confirmed that no plain water flush was used between the crushed medications mixed in water and the liquid vitamin/mineral solution.	F 658	implementation of the plan.	

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F 658	Continued From page 12	F 658		

When shown the active physician's order for the tube to be flushed between each medication, the nurse stated she didn't realize that order had not been discontinued.

An interview was conducted on 3/8/23 at 11:45 AM with the facility's Administrator. During the interview, the concern(s) identified during the medication administration observations were discussed. The concerns included the failure of the nurse to provide a free water flush between the administration of the crushed medications mixed in water and the liquid vitamin/mineral solution for Resident #25 (in accordance with the physician's order). The standards of practice related to medication administration via an enteral tube and the "cocktailing" of medications were also discussed.

A telephone interview was conducted on 3/8/23 at 1:35 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she has always instructed her facilities that if a resident was going to have an order from the physician to "cocktail meds" for medications administered via tube, the order needed to be individualized. She clarified this by further stating either the resident receiving the medications would need to be fluid-restricted or another contraindication to the water flushes identified (such as a resident becoming physically uncomfortable).

An interview was conducted on 3/9/23 at 11:51 AM with the facility's Medical Director. During the interview, the
crushing and mixing together of medications for administration to a resident via an enteral tube was discussed. The Medical Director reported a

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F 658	Continued From page 13 meeting was planned with the pharmacy consultant, facility, and herself to address this issue and to implement the practices as required and directed by the regulations. When asked, the Medical Director stated she had no questions with regard to this issue.	F 658		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and hospital and facility record reviews, the facility failed to administer water flushes via gastrostomy tube (a feeding tube inserted into the stomach) to provide hydration in accordance with the	F 693	F693 Tube Feeding Management The identified resident #25 was noted where the facility failed to administer water flushes via gastrostomy tube to	4/5/23

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F 693	Continued From page 14 physician's orders for 1 of 1 residents reviewed for tube feedings (Resident #25). The findings included: Resident #25 was admitted to the facility on 8/25/21. The resident's 8/25/21 hospital discharge summary indicated a percutaneous endoscopic gastrostomy (PEG) tube was placed due to his diagnosis of dysphagia (difficulty swallowing). A PEG tube is a feeding tube inserted through the skin and the stomach wall to provide nutrition. The resident received nothing by mouth (NPO). The resident's care plan included the following areas of focus, in part: --Resident #25 has an enteral feeding tube to meet nutritional needs related to his diagnosis of dysphagia with PEG tube placement 8/20/21 (Date Initiated: 8/25/21; Revision on 2/7/23). --Resident #25 is at risk for dehydration as evidence by all fluids provided via PEG tube (Date Initiated: 9/7/21). Resident #25's physician orders included: --Osmolite 1.5 to be administered as a continuous feeding via PEG tube at 50 milliliters (ml) per hour for 24 hours each day (Start Date 12/24/22). Osmolite 1.5 is a liquid nutritional product that provides complete, balanced nutrition for long- or short-term tube feeding for patients with increased calorie and protein needs, or for those with limited volume tolerance. The resident was NPO. --Flush tube with 200 ml of water every 6 hours. Total volume of water flushes = 800 ml/24 hours (excluding medication flushes). Total volume of nutrient plus flush = 2000 ml/24 hours as the sole	F 693	provide hydration in accordance with the physician's orders. Upon notification resident #25 flush orders were reviewed and the flush amount was immediately corrected on the pump as ordered. All residents with peg tubes have the potential to be affected. All flush orders were reviewed and pumps immediately checked at bedside to ensure that flush amount and intervals were completed as per MD orders. Education was initiated by the Director of Nursing /Nurse Practice Educator or designee on ensuring peg tube flush rate adjustments are done and correct once ordered is entered on 3/27/23 and to be completed by 4/5/23. The Director of nursing/ Assistant Director of nursing or designee will complete audits on all peg tube residents to ensure accurate flush rates 3x weekly x4 weeks to begin 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for implementation of the plan.	

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F 693	Continued From page 15	F 693		

source of hydration (Start Date 12/27/22).

Review of the resident's electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) assessment was dated 12/27/22. The MDS reported Resident #25 received nutrition via a feeding tube. The tube feeding provided 51% or more of his total calories and 501 milliliters (ml) or more per day of his average fluid intake.

A Progress Note dated 2/28/23 and authored by the facility's Nurse Practitioner revealed Resident #25 was started on an antibiotic to treat pneumonia. The diagnoses and free water intake were reported as having been discussed with the facility's Registered Dietitian (RD). A decision was made to temporarily increase the water flushes provided via PEG tube for a period of 5 days to assist with the resident's hydration.

On 2/28/23, Resident #25's previously ordered water flushes (dated 12/27/22) were put on hold from 3/1/23 to 3/5/23. A new order was received to flush the resident's PEG tube with 200 ml of water every 4 hours. Total volume of water flushes = 1200 ml/24 hours (excluding medication flushes). Total volume of nutrient plus flush = 2400 ml/24 hours for 5 days to increase flushes related to the diagnoses of pneumonia (Start Date 2/28/23 at 4:00 PM).

A review of Resident #25's physician orders and Medication Administration Record (MAR) revealed the rate of the water flush provided via tube should have been changed to include 200 ml of water every 6 hours on the evening of 3/5/23.

A medication administration observation was conducted for Resident #25 on 3/8/23 at 9:32 AM.

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At that time, the resident's enteral feeding pump was observed to be set with a water flush of 200 ml water provided every 4 hours.

A second observation of the enteral feeding pump's setting was conducted on 3/8/23 at 4:03 PM. The pump's setting remained at 200 ml water provided every 4 hours. A third observation of the pump's setting was conducted on 3/8/23 at 6:30 PM. This observation revealed the pump remained set at 200 ml water provided every 4 hours.

An interview was conducted on 3/8/23 at 6:40 PM with the hall nurse (Nurse #3) assigned to care for Resident #25. Upon request, Nurse #3 reviewed the resident's current orders for water flushes to be provided via his PEG tube. The nurse reported his current orders indicated the PEG tube should be flushed with 200 ml of water every 6 hours. Accompanied by Nurse #3, an observation was conducted of the settings on the resident's enteral feeding pump. Nurse #3 confirmed the pump was set to provide 200 ml of water every 4 hours. The nurse was observed as she changed the setting on the enteral feeding pump to provide 200 ml of water every 6 hours.

An interview was conducted on 3/9/23 at 11:12 AM with the facility's Director of Nursing (DON). During the interview, concern regarding the observed failure to provide water flushes via PEG tube in accordance with Resident #25's physician's orders was discussed. The resident's current physician orders were reviewed with the DON and Unit Manager #1 on 3/9/23 at 11:25 AM. Upon review, the DON and Unit Manager confirmed the resident's enteral feeding pump settings needed to provide 200 ml water every 6

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F 693	Continued From page 17 hours in accordance with the physician's orders.	F 693		
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 reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6% for 2 of 4 residents (Resident #69 and Resident #25) observed during medication pass. The findings included: 1. Resident #69 was admitted to the facility on 2/18/22. His cumulative diagnoses included paranoid schizophrenia. On 3/7/23 at 9:20 AM, Nurse #4 (an agency nurse) was observed as she prepared 8 oral medications for administration to Resident #69. As the nurse pulled loxapine (an antipsychotic medication) from the medication cart, she stated that she was "giving two" capsules of the medication to the resident. Nurse #4 was observed as she removed two capsules of 25 milligrams (mg) loxapine from a bubble pack medication card and placed them into a medication cup. A review of Resident #69's current physician's	F 759	F759 Free of Medication Errors Based on observations of nurse #4 and #7 during resident #69 and #25 medication administration it was noted where the facility failed to have medication error rate of less than 5%. Upon notification Nurse Practitioner was notified and 1:1 education was provided to nurse #4 and #7 regarding 5 rights of improving medication safety, to include; right patient, right drug, right dose, right time, and right route on 3/9/23. All residents have the potential to be affected. Medication Competencies was initiated for all current licensed staff, including contracted agency staff, by the Director of Nursing, Nurse Practice Educator (NPE) and/or designee. Education will be provided to all licensed nursing staff and certified medication aides by the Nurse Practice Educator, to include FT, PT, and PRN and contracted agency staff on the 5 rights of improving medication safety, to include; right patient,	4/5/23

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F 759	Continued From page 18 orders revealed his medications included the following, in part: loxapine capsule to be given as 75 milligrams (mg) by mouth two times a day for schizophrenia (Start Date 11/8/22). An interview was conducted with Nurse #4 on 3/7/23 at 1:40 PM. Upon request, the nurse pulled the loxapine bubble pack medication card from the med cart. It was noted there were 8 capsules remaining in the bubble pack card (originally containing #30 count). Nurse #4 stated she thought she gave 3 capsules to the resident for a total dose of 75 milligrams loxapine. The observation made during the med pass was then discussed, noting not only did the nurse state she was "giving two" capsules of the loxapine medication to the resident at the time she pulled the med from the cart, but she was also observed to pop two loxapine capsules out of the bubble pack card into the medication cup. When asked, Nurse #4 confirmed the medication order for the loxapine indicated 3 capsules should have been administered to the resident at the time of the med pass observation. An interview was conducted on 3/8/23 at 11:45 AM with the facility's Administrator. During the interview, the concern(s) identified during the medication administration observations were discussed. The concerns included the discrepancy between the dose of loxapine ordered by the physician (3 tablets for a total dose of 75 mg) and the dose observed to be administered (2 tablets for a total dose of 50 mg) to Resident #69. 2. Resident #25 was admitted to the facility on 8/25/21. The resident's 8/25/21 hospital discharge summary indicated a percutaneous	F 759	right drug, right dose, right time, and right route and facility policy NSG306 and Procedure: Medication Errors, as well as med availability processes established by facility. All newly hired and contracted staff will have medication administration check offs completed by the Nurse Practice Educator, Director of Nursing, Unit Managers/designee. The Director of Nursing/Nurse Practice Educator and/or designee will complete 5 random clinical competency medication administration audits with licensed nursing staff and/or certified medication aides x4 weeks to begin 03/27/23, then bi-weekly x2 weeks, then monthly x1 month. These audits will include “off shifts” and weekends”. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for implementation of the plan.	

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endoscopic gastrostomy (PEG) tube was placed due to his diagnosis of dysphagia (difficulty swallowing). A PEG tube is a feeding tube inserted through the skin and the stomach wall to provide nutrition and a route for medication administration. The resident received nothing by mouth (NPO).

Upon initiating the medication administration observation for Resident #25 on 3/8/23 at 9:28 AM, Nurse #7 reported a provider's order had been received which indicated all of the resident's medications could be crushed and administered together (cocktailed) via his PEG tube. Nurse #7 was then observed as she placed 3 tablets into a medication cup together in preparation for the med administration. The three medications included: one tablet of 10 milligrams (mg) baclofen (a muscle relaxant); one tablet of 1000 Units cholecalciferol (a Vitamin D supplement); and one tablet of 20 mg famotidine (a medication to decrease gastric acid production). The nurse then poured 15 milliliters (ml) of a liquid multivitamin/mineral solution into a separate medication cup.

On 3/8/23 at 9:32 AM, the nurse was observed as she placed the 3 tablets into a single plastic pouch, crushed the tablets together, then poured the crushed tablets back into a small medication cup. The nurse then entered Resident #25's room, washed her hands, and partially filled two plastic cups with 5-6 ounces of water from the sink. Paper towels were placed on the resident's bedside tray table and a large syringe (dated 3/8/23) was placed on the towels. At 9:34, the nurse briefly left the room to obtain a clean towel. She returned and again washed her hands and donned gloves. At 9:37 AM, the nurse cleaned

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Resident #25's PEG tube site with cleanser, dried the skin, and placed a clean gauze dressing over the site. She attached the syringe to the tubing and checked the resident's gastric (stomach) residual. Nurse #7 was then observed as poured approximately 50 ml of water from one of the cups into the syringe. The water appeared to slowly instill into the tubing; the nurse was observed to use the syringe's plunger to initiate instillation of the water from the syringe and through the tubing. At this time, Nurse #7 poured approximately 10 ml of water into the small med cup containing the 3 crushed tablets. She poured the contents of the crushed tablets mixed with water into the syringe; added approximately 5-10 ml water into the med cup three more times as she attempted to dissolve the remaining particles of the crushed tablets in the medication cup and instill the medication solution into the syringe and tubing. After the crushed tablets mixed with water were administered to the resident via his PEG tube, Nurse #7 poured the vitamin/mineral solution into the syringe for administration. No water flush was used between administering the crushed medications mixed in water and the vitamin/mineral liquid medication. Upon conclusion of the medication administration, the nurse poured approximately 50 ml of water (two times) into the syringe and tubing as a flush to finish the med administration.

A review of Resident #25's current physician orders was conducted. These orders included the following, in part:
--Enteral Feed: Flush tube with 15 ml of water before each medication pass every shift. Flush tube with at least 15 ml of water between each medication (Start Date 12/24/22).
--All crushed meds may be administered together

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F 759	Continued From page 21 (cocktailed) for this resident due to the resident being NPO (Start Date 3/7/23). An interview was conducted with Nurse #7 on 3/8/23 at 11:30 AM regarding the administration of Resident #25's medications via his PEG tube. During the discussion, the nurse confirmed that no plain water flush was used between the administration of the crushed medications mixed in water and the liquid vitamin/mineral solution. When shown the active physician's order for the tube to be flushed between each medication, the nurse stated she didn't realize that order had not been discontinued. An interview was conducted on 3/8/23 at 11:45 AM with the facility's Administrator. During the interview, the concern(s) identified during the medication administration observations were discussed. The concerns included the failure of the nurse to provide a free water flush between the administration of the crushed medications mixed in water and the liquid vitamin/mineral solution for Resident #25 (in accordance with the physician's order). The standards of practice related to medication administration via a gastrostomy tube were also discussed in detail.	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.	F 761		4/5/23

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F 761	Continued From page 22 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to: 1) Discard an expired medication (Memory Care Medication Store Room); 2) Discard an expired insulin pen and date an insulin pen as to when it was placed on the medication cart and/or opened to allow for the determination of their shortened expiration date (100 South Medication Cart A); 3) Store medications in accordance with the manufacturer's storage instructions (100 North Medication Cart A); and 4) Store a controlled substance medication in a container that was not clearly labeled with the minimum required information (100 North Medication Cart B). This occurred for 1 of 3 medication storage rooms and 3 of 5 medication carts observed. The findings included:	F 761	F761 Label/Storage of Drugs The facility failed to discard expired medication in the memory care medication store room, discard expired insulin pen, date insulin pen and failed to store controlled substance medication that was marked on 100 north medication cart B. Upon notification outdated medications and medication not properly stored on the medication cart and mediation storage room were discarded per policy and reordered by the Unit Manager. All residents have the potential to be affected. Medication Carts and Medication Store rooms were audited by the Director of Nursing and Unit Managers to ensure that all medications were dated and	

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F 761	Continued From page 23 1. An observation was conducted on 3/7/23 at 4:15 PM of the Memory Care Medication Storage Room in the presence of Nurse #4. The observation revealed one opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. The outside of the manufacturer's box containing the vial of medication was dated "12/26/22." Upon request, Nurse #4 examined the vial and manufacturer box. When Nurse #4 was asked how long the Tuberculin PPD injectable medication should be kept, the nurse stated she thought it could be kept for 30 days after opening. Nurse #4 reported the medication needed to be discarded. The manufacturer's storage instructions and labeling on the box for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days. An interview was conducted on 3/9/23 at 11:12 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would medications to be stored in accordance with the manufacturer's recommendations. 2. An observation was conducted on 3/8/23 at 9:50 AM of the 100 South Medication (Med) Cart A in the presence of the facility's Director of Nursing (DON). The observation revealed an opened insulin Lispro pen stored in a plastic bag on the cart was not labeled with the date it had been opened. The pharmacy label on the insulin pen indicated it was dispensed from the pharmacy on 2/5/23 for Resident #49. A yellow	F 761	properly labeled/stored on 3/10/23. Medication Storage in-service will be given to all nursing staff, new hires and contracted agency staff by the Director of Nursing, Nurse Practice Educator and/or designee. Quick reference guides from Pharmacy on medication storage were added to each medication cart. All newly hired and contracted staff will have medication storage education completed by the Nurse Practice Educator, Director of Nursing, Unit Managers/designee. The Director of nursing/ Assistant Director of nursing or designee will complete audits on all medication carts and medication storage rooms to ensure all mediations are stored in accordance to manufacturer's instructed, properly dated, and no expired medications 3x weekly x4 weeks to begin 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for implementation of the plan.	

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auxiliary sticker placed on the plastic bag read, "Date opened [blank]. Expires [blank]. Refrigerate until opened. Discard unused med at 28 days."

An interview was conducted with the DON at the time of the observation on 3/8/23 at 9:50 AM. The DON reported an insulin pen was supposed to be stored in the refrigerator until it was time to use it. She also stated she would expect an insulin pen to be dated either when it was put on the med cart or put into use (whichever occurred first) and discarded in accordance with the manufacturer's instructions.

According to the product manufacturer, unopened insulin Lispro pens may be stored under refrigeration until the manufacturer's expiration date or at room temperature for 28 days. Prefilled pens that have been punctured (in use), should be stored at room temperatures and used within 28 days.

3) An observation was conducted on 3/8/23 at 10:02 AM of the 100 North Med Cart A in the presence of Nurse #5 and Unit Manager #2. The observation revealed 1 loose vial of 0.5 milligrams (mg) / 3 mg ipratropium/albuterol solution for inhalation dispensed for Resident #24 was found stored outside of the foil pouch on the med cart; the vial was not dated as to when it had been removed from the foil pouch. Storage instructions on the manufacturer's box indicated if a vial was removed from the foil pouch, it should be used within 2 weeks.

An interview was conducted on 3/9/23 at 11:12 AM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage

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observations. During the interview, the DON stated she would expect medications to be stored in accordance with the manufacturer's recommendations.

4) An observation was conducted on 3/8/23 at 10:15 AM of the 100 North Med Cart B in the presence of Nurse #6. The observation revealed a vial of medication stored in the controlled substance drawer had a printed label with most of the print appearing to be worn off. Parts of the labeling on the vial were unreadable. The manufacturer of the medication, prescription number, and dispensing pharmacy could not be read; the resident's name and name of the medication were difficult to read. Further inspection of the vial revealed it contained 23 tablets. These tablets included 12 white oval tablets and 11 peach oblong tablets. The markings on the tablets confirmed each was a 10 milligrams (mg) tablet of zolpidem (a controlled medication used to treat insomnia) from two different manufacturers. An interview was conducted with Nurse #6 at the time of the observation. When asked who this medication belonged to, Nurse #6 stated the medication was brought from home for Resident #116. However, the nurse also reported she could barely read the label because the print was "very faint." Upon review of the controlled substance log kept on the 100 North Med Cart B, it was determined none of these tablets had been administered to Resident #116.

Unit Manager #1 joined the nurse at the med cart upon conclusion of the med cart observation conducted on 3/8/23 at 10:15 AM. At that time, the Unit Manager reported the vial of tablets needed to be sent home with the resident's

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F 761	Continued From page 26 family.	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff, and registered dietitian (RD)interviews, and record reviews, the facility failed to provide all of the food items as specified by the planned menu for 1 of 1 residents (Resident # 23) during 2 of 3 meal observations conducted. This had the potential to	F 803	F803 Menus to Meet Resident Needs Resident #23 was offered and upon request, provided their missing drink items and food items at time of identification.	4/5/23

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F 803	Continued From page 27 affect other residents in the facility. The findings included: Resident #23 was readmitted to the facility on 6/5/19. Review of the physician order's revealed Resident #23 received regular, Dysphagia puree texture diet, Honey Thick Liquids- consistency and double potions. The order also indicated the resident could have soft breads, biscuits and gravy, soft desserts and cereal as needed. Review of the Quarterly Minimum Data Set (MDS) assessment dated 1/28/23 revealed Resident #23 was assessed as moderately cognitively impaired and required total assistance with one-person physical assistance for Activity of Daily Living (ADL) including eating. On 3/6/23 at around 1:00 PM, the Dietary District manager was observed bringing a small pan of pureed beans to the second-floor satellite dining room. The Dietary District manager indicated the kitchen had forgotten to send the pureed beans to the dining room. He further indicated all residents on a pureed diet would be sent a bowl of pureed beans. During a lunch meal observation on 3/6/23 at 1:10 PM, Resident #23 was observed being feed by staff in his room. Review of Resident #23's meal/ tray ticket revealed the resident was on a regular- pureed diet with double portions and on honey thick liquids. The meal ticket indicated pureed turkey and swiss for sandwich, pureed bread, pureed seasoned potato wedges (no skin), puree seasoned green beans, apple sauce,	F 803	All residents have the potential to be affected. Center Registered Dietician and Dining Services Management will review and complete 100% audit of resident meal tickets for errors indicating the resident would get both the alternate meal and the primary meal on or before 4/5/23. Center nursing, dining, activities and interdisciplinary staff will be educated by the Assistant Administrator on the process for passing resident beverages and the process if a drink item or food item is not on the beverage cart or resident tray on or before 4/5/23. Dining Staff will be educated by the Assistant Administrator to ensure resident beverages and menu items are available for the center staff to distribute to the residents on or before 4/5/23. Dining Staff will be educated by the Assistant Administrator to ensure resident beverage and resident meal items for all diet consistencies are honored and available for the center staff to distribute to the residents on or before 4/5/23. The Assistant Administrator/designee will complete 5 random audits for drink preferences and required meal items weekly for x4 weeks to begin 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification	

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F 803	Continued From page 28 honey like 2% milk - 16 oz. (ounces), Honey like sweet tea - 8 oz. and Honey like Apple juice 3/4 cup. Observation of the resident's tray revealed the resident was not served pureed seasoned green beans, 2% milk (honey thick) - 16 ounces (oz.), and apple juice (honey thick) - ¾ cup. During an interview on 3/6/23 at 1:13 PM, the unit manager #2 who was assisting the resident with feeding indicated she was unsure why the resident had not received the food items indicated on his meal ticket. On 3/6/23 at 1:45 PM, during an interview unit manager #2 stated the resident had not received a bowl of pureed beans and has consumed 100% of the tray that was served to him. The unit manger #2 further stated the resident consumed honey thick water and honey thick sweet tea and did not receive any milk or apple juice from the dietary department. During an observation and interview on 3/7/23 at 9:00 AM, Resident #23 was observed assisted with feeding in his room. Unit manager #2 was assisting resident with feeding. Review of Resident #23's meal/tray ticket revealed puree scrambled egg, puree apple pancakes, margarine -2 each, syrup 4 oz. puree grits, puree breakfast grilled ham slice, puree sausage link, brown gravy 1 oz. apple juice honey thick 3/4 cup and honey thick coffee 3/4 cup. Observation of the tray served to the resident revealed pureed apple pancakes, margarine -2 each, syrup, pureed sausage link with brown Gravy - 1 oz were not served to the resident. During an interview the unit manager #2 stated the resident did not receive any pureed pancakes or sausage links. The unit manager #2 stated the resident would	F 803	of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Assistant Administrator will be responsible for implementation of the plan.	

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receive only one of the option on the meal ticket and hence did not receive puree pancakes and puree sausage links and received only puree grits and puree ham.

On 3/7/23 at 5:45 PM, during an interview with registered dietitian (RD), she stated the resident was regular pureed, honey thick liquids with double portions. She indicated the resident could not self-feed and was assisted with feeding. The RD stated Resident #23 should receive all the menu items indicated on the meal/ tray ticket for lunch meal on 3/6/23. Regarding breakfast on 3/7/23 the RD indicated the resident should receive eggs, pancakes, girts (resident preference) and ham. The sausage link (puree) on the meal ticket was the alternate meat option. The resident should also receive honey thick coffee and honey thick apple juice as beverages. The RD stated the dietary staff/ aide should review the tray tickets to ensure all the menu items printed on the ticket were available to the resident. If the item was not available, then the dietary aide should alert the dietary manager. If food indicated in the menu was unavailable it should be prepared, or equal nutrition substitution should be made and offered to the residents.

During an interview on 3/8/23 at 12:50 PM, the dietary manager stated that when the kitchen was made aware that the puree trays did not have one food item listed on the menu, the kitchen immediately sent out the food item and the residents were provided the pureed green beans later. The dietary manager indicated the dietary staff checked the meal ticket prior to plating to ensure the tray was accurate.

During an interview on 3/8/23 at 1:55 PM, the

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F 803	Continued From page 30 district dietary manager stated the staff in the main kitchen had to check the production sheet per location and send food items appropriately to the different dining areas where the food was served to the residents. The dietary staff was supposed to check if all items were available before plating the meals. If any food item was not available, then the staff should not plate and notify the kitchen about the unavailable item. Once the item was available, then all the pureed trays should have been plated. During an interview on 03/09/23 11:17 AM, the administrator stated the dietary staff should ensure the resident's food preference were honored and all menu item should be provided unless the resident had requested something different and was substituted per his request.	F 803		
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- §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 observations, record review, and staff interviews the facility failed to honor the food and or beverage preferences for 3 of 3 residents observed during dining (Resident #120, Resident #62, and Resident #112).	F 806	F806 Resident Preferences Resident #120, 62 and 112 were all offered and upon request, provided their missing preferences at time of	4/5/23

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F 806	Continued From page 31 Findings included: 1. Resident #120 was admitted to the facility on 10/29/20. Review of the quarterly minimum data set (MDS) assessment dated 12/21/22 for Resident #120 revealed the resident was assessed as cognitively impaired, needing supervision with one-person physical assistance with eating. Review of the care plan (12/28/22) revealed the resident was care planned for communication due to language barriers. Resident communicated using gestures and a communication book. During lunch meal observation on 3/6/23 at 1:20 PM, Resident #120 was observed consuming his lunch in his room. Review of the resident's meal ticket revealed chocolate milk (8 ounce). Observation of the resident's meal tray revealed there was no chocolate milk on the tray. When the resident was asked if he liked chocolate milk, he nodded his head indicating he liked chocolate milk. During an interview and observation on 3/6/23 at 1:25 PM, Nurse aide (NA) #4 stated she usually knew what the residents drank for beverages and offered those beverages. She indicated the meal tickets were wrong and not updated correctly. NA #4 indicated most of the residents did not drink milk and hence was not offered. NA further indicated that there was no chocolate milk on the cart and hence not offered to the resident. Observation of the beverage cart revealed multiple milk cartons but no chocolate milk.	F 806	identification. All residents have the potential to be affected. Center Registered Dietician and Dining Services Management will review and complete 100% update of resident drink preferences to include resident, staff and family interviews, as appropriate, on or before 4/5/23. Center staff will be educated by the Assistant Administrator on the process for passing resident beverages and the process if a desired preference is not on the beverage cart or resident tray on or before 4/5/23. Dining Staff will be educated by the Assistant Administrator to ensure resident beverage preferences are honored and available for the center staff to distribute to the residents on or before 4/5/23. The Assistant Administrator/designee will complete 5 random audits for dining preferences weekly for x4 weeks to begin 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Assistant Administrator will be responsible for implementation of the plan.	

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During lunch meal observation on 3/7/23 at 12:50 PM, Resident #120 was observed consuming his lunch in his room. Observation of the resident's meal tray and review of the meal ticket revealed there was no chocolate milk (8 ounce) on the tray. When the resident was asked if he received chocolate milk, he nodded his head indicating "No".

During lunch meal observation on 3/08/23 at 1:46 PM, Resident #120 was observed consuming his lunch in his room. Observation of the resident's meal tray revealed the resident did not receive chocolate milk (8 ounce) or the dessert for the day (vanilla ice cream). When asked if he liked ice cream, Resident #120 nodded he liked it and indicated he wanted it.

During an interview on 3/8/23 at 1:20 PM, NA # 3 indicated she had served the lunch tray to the resident. NA #3 stated the meal tray distribution process was very confusing as one NA was serving drinks, one NA was serving meal trays and another NA was serving condiments and desserts. It was hard to keep track of what a resident received and did not receive.

During an interview and observation on 3/8/23 at 12:50 PM, the Dietary Manager stated chocolate milk should be available on the beverage cart. Observation of the cart revealed there was no chocolate milk on the cart. The Dietary Manager stated the staff distributing the beverages should contact the kitchen if any item was unavailable to be offered to the resident.

During an interview on 3/7/23 at 5:33 PM, the Registered Dietitian (RD) indicated Resident

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#120 was on a regular diet with double portions for breakfast. RD stated per resident's preference, the resident would receive assorted fruit juice, chocolate milk (8 ounce) and coffee for breakfast. For resident's lunch and dinner, the resident preferred chocolate milk and sweet tea. RD indicated the resident was able to communicate his needs by nodding or using signs. The resident cannot communicate in English but could respond to simple questions when asked.

2. Resident #62 was readmitted to the facility on 11/3/22.

Review of the quarterly MDS assessment dated 1/16/23 revealed Resident #62 was assessed as cognitively intact and needed supervision with set up help only for eating.

During a lunch meal observation and interview on 3/06/23 at 1:00 PM, Resident #62 was observed consuming her lunch in her room. Review of the resident's tray card revealed 2% milk (4 ounce), 2 - unsweetened iced tea (8 ounce). Observation of the meal tray revealed the resident did not receive 2% milk (4 ounce). Resident #62 indicated she preferred to have milk with her meals, however, was offered only iced tea. She further indicated she never received any milk or juice with her meals.

During an interview and observation on 3/6/23 at 1:25 PM, Nurse aide (NA) #4 stated she usually knew what the residents drank for beverages and offered those beverages. She indicated the meal tickets were wrong and not updated correctly. NA #4 indicated most of the residents did not drink milk and hence was not offered. Observation of

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the beverage cart revealed multiple milk cartons on the cart.

During an interview on 3/7/23 at 5:33 PM, the Registered Dietitian (RD) indicated Resident #62 was on regular diet. RD stated Resident # 62's beverage preferences for breakfast was 2% milk, cranberry juice, and coffee. Lunch and dinner preferences were unsweetened iced tea. RD further stated the staff could ask what the resident preferred with her meals beside unsweetened iced tea. RD stated that recently changes were made as to how the meal ticket was printed. Previously the dietary department was not utilizing the nutrition software optimally and the meal ticket was only printing the resident's name, diet, and preferences. With the changes in system, food items in the menu, the default beverage options that include milk and assorted beverages were printed on the meal ticket along with the resident beverage preferences. If no preferences were indicated the staff serving the beverages needed to ask the resident their preferences for each meal. RD stated the resident's food and beverage preferences were updated frequently.

3. Resident #112 was admitted to the facility on 3/19/20.

Review of the annual MDS assessment dated 12/30/22 revealed Resident #62 was assessed as cognitively intact and needed supervision with set up help only for eating.

During a lunch meal observation and interview on 3/06/23 at 1:15 PM, Resident #112 was observed consuming her lunch in her room. Review of the resident's tray card revealed 2% milk (16 ounce),

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Lemonade - (8 ounces), Cranberry juice -3/4 cup as beverages. Observation of the meal tray revealed the resident did not receive 2% milk, lemonade, and cranberry juice. The resident received iced tea (2 cups) with her meals. Resident #112 stated on few occasions she had some issues with her stomach and was not able to tolerate lemonade. She further stated on few occasions she could not tolerate milk. She indicated she preferred that the staff asked her the choice of beverage she would like instead of just serving her iced tea.

During an interview and observation on 3/6/23 at 1:25 PM, Nurse Aide (NA) #4 stated she usually knew what the residents drank for beverages and offered those beverages. She indicated the meal tickets were wrong and not updated correctly. NA #4 indicated most of the residents did not drink milk and hence was not offered. Observation of the beverage cart revealed multiple milk cartons on the cart. There was no lemonade jug on the cart.

During an interview on 3/7/23 at 5:08 PM, the Registered Dietitian (RD) indicated Resident #112 was on regular diet. RD stated Resident # 112's beverage preferences for breakfast were whole milk, and apple juice. Lunch and dinner the resident preferred cranberry juice and sweet tea. RD further stated the staff should ask what the resident preferred with her meals beside unsweetened iced tea. RD stated that recently changes were made as to how the meal ticket was printed. Previously the dietary department was not utilizing the nutrition software optimally and the meal ticket was only printing the resident's name, diet, and preferences. With the changes in system, food items in the menu, the

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F 806	Continued From page 36 default beverage options that include milk and assorted beverages were printed on the meal ticket along with the resident beverage preferences. If no preferences were indicated the staff serving the beverages needed to ask the resident their preferences for each meal. RD stated the resident's food and beverage preferences were updated frequently. During an interview on 03/09/23 11:17 AM, the Administrator stated the dietary staff should ensure the residents' food preference were honored and all items on the meal ticket should be provided unless the resident had requested something different and was substituted per his request.	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.	F 812		4/5/23

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F 812	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to maintain a clean convention oven, walk-in refrigerator, walk-in freezer, and kitchen floor. The facility also failed to maintain clean nourishment room refrigerators, label and date leftover food for 2 of 3 nourishment refrigerators reviewed (nourishment refrigerator #2 on 200 hallway (Homestead) and refrigerator #3 (in Homestead dining area)). Findings included: 1. During an observation on 3/6/23 at 9:45 AM, the convention oven had large volume of a grease buildup, and dried food particles inside of the oven. The grease buildup was encrusted on doors and on shelves where food would be cooked. There was a large volume of dried grease buildup observed on the fronts of the oven and on the walls. The baking sheet pan inside the oven had large volume of dark brown grease built up on it. During an interview on 3/6/23 at 9:50 AM, the district dietary manager stated the convention oven needed to be cleaned and should not have grease built up in it. On 3/09/23 at 11:15 AM, the dietary manager stated the kitchen had cleaning schedule to clean the kitchen and kitchen equipment. This cleaning list was currently being updated and the dietary manager was working on it. The dietary manager indicated based on the cleaning schedule, the cook (both AM and PM cooks) were responsible to clean the ovens weekly. She indicated the cooks had not cleaned the oven the previous	F 812	F812 Sanitation Upon identification, the convection oven was cleaned by the Dietary Manager on 3/6/2023, the walk in freezer, kitchen floor and refrigerator were cleaned by the Dietary Manager on 3/6/2023, and the nourishment refrigerators on the Homestead unit dining room and nourishment room were cleaned and non-dated and staff food items were discarded by the Dining Manager on 3/6/2023 All residents have the potential to be affected. Education for the dining staff on sanitation expectations and cleaning practices will be completed by the Assistant Administrator/designee on or before 4/5/23. Education for all staff on sanitation of nourishment room refrigerators, labeling, dating and the storage of non-resident items will be completed by the Assistant Administrator/designee on or before 4/5/23. This education will also be completed upon hire for staff to include new contracted agency orientation. The Assistant Administrator/ designee will complete 5 random nourishment room/refrigerator audits x4 weeks to begin on 3/27/23, then bi-weekly x2 weeks, then monthly x1 month. The Assistant Administrator/designee will complete twice weekly kitchen sanitation rounds to begin on 3/27/23then bi-weekly x2 weeks,	

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F 812	Continued From page 38 week and had not completed the task. The cook was unavailable to be interviewed. 2a. Observation of the walk-in refrigerator on 3/6/23 at 9:55 AM revealed sticky floors, on one side of the refrigerator floor under the food racks which stocked frozen meat for thawing, had a big dark pinkish red stain. On the other side of the walk-in refrigerator floor was a crushed juice cup. 2b. Observation of the walk-in freezer floor on 3/6/23 at 10:00 AM, the floor was sticky. There was ice on the floor below the compressor. The 2 white colored cardboard box with frozen food under the compressor had ice on them. During an interview on 3/6/23 at 10:00 AM, the district dietary manager indicated the walk-in refrigerator floor and walk-in freezer should have been cleaned. Review of the cleaning schedule revealed the dietary manager was responsible to clean the refrigerators and freezers both daily and weekly. During an interview on 3/9/23 at 11:15 AM, the dietary manager indicated the kitchen floors were cleaned daily. She further stated on 3/6/23, they had food delivered that morning and hence the floor was dirty. 4a. Observation of the nourishment refrigerator #2 (on the 200 hallway - Homestead) at 3/6/23 at 10:15 AM revealed a big cardboard box with "Pizza" printed on it and labeled "for employee appreciation - third shift", the cardboard box was not dated. A dark colored covered cup, labeled 2/15 with food in it. The Dietary manager	F 812	then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Assistant Administrator will be responsible for implementation of the plan.	

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F 812	Continued From page 39	F 812		

indicated the cup contained pudding that was to be used on medication cart. A grey plastic grocery bag with no label containing 2 oranges, 2 packs of crackers and a pack of tuna salad. The freezer contained a grey grocery plastic bag with 4 individual wrapped ice-cream sandwich with no label or expiration date.

During an interview on 3/6/23 at 10:17 AM, the dietary manager indicated she was responsible for cleaning the nourishment refrigerators, however she had not been cleaning the refrigerators for past few days as the kitchen was having staffing issues and she was assigned to work in the kitchen. She indicated she was responsible to check and clear food in the nourishment refrigerator. She further indicated employees were not supposed to place personal food in the nourishment refrigerator. All food brought in by resident or resident's family should be labeled with resident's name and date the food was placed in the refrigerator.

4b. Observation of the nourishment refrigerator #3 (200 hallway -in Homestead dining room) at 3/6/23 at 10:20 AM revealed 3 clear plastic jugs with some colored fluids in the bottom with no label. The refrigerator floor and shelves had orange-colored stains on them. The freezer had three 8 oz. (ounce) water bottles with no label. One bottle was 3/4 filled with orange colored frozen liquid, one bottle was half filled with a whitish creamy frozen liquid, one bottle was 3/4 filled with water and frozen. The shelf and floor of the freezer had orange brownish colored stains on them.

During an interview on 3/6/23 at 10:25 AM, the dietary manager indicated she was responsible

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F 812	Continued From page 40 for cleaning the nourishment refrigerators, however she had not been cleaning the nourishment refrigerators for past few days as the kitchen was having staffing issues and she was assigned to work in the kitchen. During an interview on 3/9/23 at 11:17 AM, the administrator stated all of the kitchen equipment and floors should be cleaned as per scheduled. The scheduled should be followed by the dietary staff. The administrator further stated employees/ staff should not place their personal food in resident's nourishment refrigerator and the nourishment refrigerators should be maintained clean. All food brought in by the residents or residents' family should be labeled with resident's name and date the food was placed in the nourishment refrigerator prior to placing food in the refrigerator. All foods should be discarded per policy.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		4/5/23

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F 842	Continued From page 41 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 42 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff and consultant pharmacist interviews and record reviews, the facility failed to retain the consultant pharmacist's recommendations and provider responses in the resident's medical record or within the facility so the records were readily available for 3 of 5 residents reviewed for unnecessary medications (Resident #10, Resident #132, and Resident #49). The findings included: 1. Resident #10 was admitted to the facility on 7/31/20. Her cumulative diagnoses included bipolar disorder, anxiety disorder, and adult failure to thrive. A review of Resident #10's electronic medical record (EMR) included the monthly Medication Regimen Reviews (MRRs) completed by the consultant pharmacist from March 2022 through February 2023. The resident's EMR revealed the following: --On 5/24/22, an MRR was performed by the pharmacist. The pharmacist's notation indicated, "Comment / Recommendation noted - see report." The pharmacist's Consultation Report	F 842	F842 Resident Records Upon review the facility failed to retain consultant pharmacist recommendations and provider responses in the medical record or within the facility as evidenced by resident #10, #132, and #49. The noted forms for the above residents were reviewed and signed by the assigned providers and placed in the respective medical record on 3/27/23. All residents have the potential to be affected. Pharmacy consulted and an audit was completed for 90 day look back (dec-feb) to identify any pertinent consult sheets that are pending to be addressed and not in the Medical record by the Consultant Pharmacist on 3/22/23. In-Service was completed on 3/27/23 by the Director of Nursing with Unit managers, Nurse Practitioners and Medical Director on turn around time of consult sheets to be addressed and 1:1 education with medical records personnel on ensuring pharmacy recommendations	

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F 842	Continued From page 43 and signed provider response were not available for review. No additional information could be provided by the facility related to the consultant pharmacist's recommendations. --Monthly MRRs dated 7/14/22, 8/22/22, and 9/19/22 were included in Resident #10's EMR. The pharmacist made a notation for each of these MRRs which read, "Comment / Recommendation noted - see report." The pharmacist's Consultation Reports and signed provider responses were not available for review. No additional information could be provided by the facility related to the consultant pharmacist's recommendations made on any of these dates. An interview was conducted with the facility's Administrator on 3/8/23 at 4:00 PM. During the interview, the Administrator revealed she was unable to locate the Pharmacy Consult book and all of the recommendations made by the consultant pharmacist. A second interview was conducted with the Administrator on 3/9/23 at 1:46 PM to discuss the MRR Consultation Reports completed by the pharmacist. When asked where the signed forms with the Physician's Responses to the pharmacist's recommendations were kept, the Administrator reported the facility could not find all of them. This interview continued on 3/9/23 at 2:00 PM with the Administration and Director of Nursing (DON). The DON described the process the facility used to receive the pharmacist's Consult Reports, distribute them to the provider(s) for review, implement the recommendations (if accepted by the provider), and retain the Consult Report with the provider's response in residents' medical records. The DON reported she was aware both the	F 842	are scanned to the resident charts. The Director of Nursing/ Assistant Director of nursing or designee will complete audits of resident care records to ensure that all pharmacy recommendations have been completed and uploaded weekly to begin 3/27/23 x4 weeks, then bi-weekly x2 weeks, then monthly x1 month. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. The Director of Nursing and Nurse Practice Educator will be responsible for implementation of the plan.	

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pharmacist's recommendation(s) and signed provider's response needed to be readily available for review. The DON and Administrator reported the facility had self-identified this issue and felt it had been corrected.

A follow-up interview was conducted with the Administrator on 3/9/23 at 3:00 PM. During the interview, the Administrator reported the facility's plan of correction (POC) related to the failure to retain the consultant pharmacist's recommendations and provider responses was not as complete as it needed to be. The Administrator reported this POC would not be submitted for consideration.

A telephone interview was conducted on 3/9/23 at 3:48 PM with the facility's consultant pharmacist. During the interview, the pharmacist was informed of concerns regarding the facility's failure to retain the pharmacist's Consult Reports and/or provider responses. The pharmacist reported she had been made aware of the concern and facility's work on addressing this issue.

2. Resident #132 was admitted to the facility on 7/30/21. His cumulative diagnoses included a developmental disorder and non-Alzheimer's disease.

A review of Resident #132's electronic medical record (EMR) included the monthly Medication Regimen Reviews (MRRs) completed by the consultant pharmacist from March 2022 through February 2023. The resident's EMR revealed the following:
--On 6/17/22, an MRR was performed by the pharmacist. The pharmacist's notation indicated,

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"Comment / Recommendation noted - see report." The pharmacist's Consultation Report (dated 6/17/22) read in part, "Comment: [Resident #132] has received an antipsychotic, Zyprexa Zydis [an antipsychotic medication] 5 mg [milligrams] two times a day for Psychosis since 3/10/22. Recommendation: Please attempt a gradual dose reduction (GDR)." The "Physician's Response" was not completed or signed by the provider.
--On 9/19/22, an MRR was performed by the pharmacist. The pharmacist's notation indicated, "Comment / Recommendation noted - see report." The pharmacist's Consultation Report and signed provider response were not available for review. No additional information could be provided by the facility related to the consultant pharmacist's recommendations.
--On 11/17/22, an MRR was performed by the pharmacist. The pharmacist's notation indicated, "Comment / Recommendation noted - see report." The pharmacist's Consultation Report and signed provider response were not available for review. No additional information could be provided by the facility related to the consultant pharmacist's recommendations.

An interview was conducted with the facility's Administrator on 3/8/23 at 4:00 PM. During the interview, the Administrator revealed she was unable to locate the Pharmacy Consult book and all of the recommendations made by the consultant pharmacist.

A second interview was conducted with the Administrator on 3/9/23 at 1:46 PM to discuss the MRR Consultation Reports completed by the pharmacist. When asked where the signed forms with the Physician's Responses to the

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pharmacist's recommendations were kept, the Administrator reported the facility could not find all of them. This interview continued on 3/9/23 at 2:00 PM with the Administration and Director of Nursing (DON). The DON described the process the facility used to receive the pharmacist's Consult Reports, distribute them to the provider(s) for review, implement the recommendations (if accepted by the provider), and retain the Consult Report with the provider's response in residents' medical records. The DON reported she was aware both the pharmacist's recommendation(s) and signed provider's response needed to be readily available for review. The DON and Administrator reported the facility had self-identified this issue and felt it had been corrected.

A follow-up interview was conducted with the Administrator on 3/9/23 at 3:00 PM. During the interview, the Administrator reported the facility's plan of correction (POC) related to the failure to retain the consultant pharmacist's recommendations and provider responses was not as complete as it needed to be. The Administrator reported this POC would not be submitted for consideration.

A telephone interview was conducted on 3/9/23 at 3:48 PM with the facility's consultant pharmacist. During the interview, the pharmacist was informed of concerns regarding the facility's failure to retain the pharmacist's Consult Reports and/or provider responses. The pharmacist reported she had been made aware of the concern and facility's work on addressing this issue.

3. Resident #49 admitted to the facility on 01/17/23 and had diagnoses which included

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F 842	Continued From page 47 diabetes mellitus, chronic kidney disease, heart failure, depression, and hypertension. A review of Resident #49's pharmacy medication regimen reviews (MRR) consultation reports from March 2022 to February 2023 revealed the months of August 2022 and February 2023 recommendations were missing from the medical record. On 03/08/23 at 4:00 PM an interview was conducted with the Administrator, and she indicated she was unable to locate the pharmacy consult book and the recommendations that were made by the pharmacist for Resident #49 for August 2022 and February 2023. A second interview was conducted with the Administrator on 3/9/23 at 1:46 PM. The Administrator reported the facility could not find all the signed forms with the Physician's Responses to the pharmacist's recommendations. The Director of Nursing (DON) joined the interview and described the process the facility used to receive the pharmacist's Consult Reports, distribute them to the provider(s) for review, implement the recommendations (if accepted by the provider), and retain the Consult Report with the provider's response in residents' medical records. The DON reported she was aware both the pharmacist's recommendation(s) and signed provider's response needed to be readily available for review.	F 842		
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	F 867		4/5/23

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F 867	Continued From page 48	F 867		

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.

§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

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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, 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.

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F 867	Continued From page 50 §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 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification survey dated 7/19/21 and complaint investigation on 4/14/21 to achieve and sustain compliance. This was for recited deficiencies on a	F 867	F867 QAA Facility received four repeat citations during the compliant and recertification survey that had been cited during prior surveys. Revised plans have been developed to address those areas with	

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F 867	Continued From page 51 recertification survey on 3/10/23. The deficiencies were in the areas of tube feeding management, pharmacy services, and dietary services. The continued failure during four federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F693 - Based on observations, staff interviews, and hospital and facility record reviews, the facility failed to administer water flushes via gastrostomy tube to provide hydration in accordance with the physician's orders for 1 of 1 resident reviewed for tube feeding management (Resident #25). During the previous recertification survey on 7/19/21, the facility failed to (1) store a tube feeding syringe with the plunger separated from the syringe, which created the potential for bacteria growth, for 1 of 1 resident and (2) administer enteral feeding as ordered. This occurred for 1 of 3 residents observed for tube feeding management. F761 - Based on observations, staff interviews and record reviews, the facility failed to: 1) Discard an expired medication (Memory Care Medication Store Room); 2) Discard an expired insulin pen and date an insulin pen as to when it was placed on the medication cart and/or opened to allow for the determination of their shortened expiration date (100 South Medication Cart A); 3) Store medications in accordance with the manufacturer's storage instructions (100 North	F 867	ongoing monitoring by the Quality Assurance Performance Improvement Committee. Plans for tube feeding management (F693), pharmacy services (F761) and dietary services (F806 and F812). All residents have potential to be affected. Root Cause Analysis completed by the interdisciplinary Quality Assurance Team for each of these deficiencies to determine the systemic break that led to the deficient practice with revised plans developed to address these areas. Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Regional Nurse. (QAPI team consists of Administrator, Assistant Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resources Manager, Maintenance Director, Social Services Director, Homestead Program Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director) Licensed staff, nurses assistants, maintenance personnel, activities, receptionists, dietary, housekeeping, laundry, therapy and additional Interdisciplinary team members were all educated by the Administrator on Quality Assurance and recognizing areas for Performance Improvement and how to report these findings to the QAPI Committee on or before 4/5/2023.	

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F 867	Continued From page 52 Medication Cart A); and 4) Store a controlled substance medication in a container that was not clearly labeled with the minimum required information (100 North Medication Cart B). This occurred for 1 of 3 medication storage rooms and 3 of 5 medication carts observed. During the previous recertification survey on 7/19/21, the facility failed to store medications in accordance with the manufacturer's storage instructions in 1 of 5 medication carts observed (2 south Hall Cart) and failed to date insulin when opened for use in 1 of 5 medication carts (1 North Hall Cart). F806 - Based on observations, record review, and staff interviews the facility failed to honor the food and or beverage preferences for 3 of 3 residents observed during dining (Resident #120, Resident #62, and Resident #112). During the previous recertification survey on 7/19/21, the facility failed to provide the resident eggs in preferred form. The preference was printed on her dietary meal ticket but not provided on her meal tray for 1 of 6 halls observed during dining. F812 - Based on observations and staff interviews, the facility failed to maintain a clean convention oven, walk-in refrigerator, walk-in freezer, and kitchen floor. The facility also failed to maintain clean nourishment room refrigerators, label and date leftover food for 2 of 3 nourishment refrigerators reviewed (nourishment refrigerator #2 on 200 hallway (Homestead) and refrigerator #3 (in Homestead dining area). During the previous complaint investigation on	F 867	The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/ interventions to prevent recurring non-compliance. The Administrator will be responsible for implementation of the plan.	

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F 867	Continued From page 53 4/14/21, the facility failed to ensure the plate covers used to cover the residents prepared meal plates were dry. The facility additionally failed to ensure a staff member serving the resident's meal had on a hair restraint. This was evident for 1 of 1 meal service observation. An interview with the Administrator was conducted on 3/9/23 at 4:15 PM. She stated the QA committee discussed areas of concern monthly by tracking and trending with root cause analysis identified. The QA committee uses tools to develop plans, audits, and ongoing monitoring to discuss outcomes. The Administrator also stated the concerns were identified and prioritized in QA meetings. She indicated concerns were continuously monitored for best outcomes. Furthermore, the Administrator indicated she expected to not have repeated deficiencies and continues with standards per state regulations.	F 867		