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	345428	A. BUILDING _____ B. WING _____	C 08/21/2023

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/13/2023 through 8/21/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OCR911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 8/13/2023 through 8/18/2023. Event ID # OCR911. Additional information was obtained on 8/21/2023, and the survey end date was changed to 8/21/2023. The following intakes were investigated NC00197182, NC00200012, NC00200491, NC00202659, NC00206035, NC00195947, and NC00198864. 4 of the 14 complaint allegations resulted in deficiency. Intake NC00202659 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/5/2023 and was removed on 8/16/2023. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		9/11/23

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

Electronically Signed | 09/07/2023

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F 600	Continued From page 1 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with Resident, Responsible Party, staff, Nurse Practitioner and Police Department Dispatcher, the facility failed to protect the rights of two residents to be free from resident-to-resident physical abuse. Resident #164 was placed on one-to-one observation prior to the first resident to resident physical abuse incident of 4/5/23 due to aggressive behaviors with staff and exit seeking behaviors. On 4/5/23, Resident #164 went onto Resident #165's bed and put his arm around Resident #165's neck in a chokehold when staff intervened. On 5/4/2023 Resident #164 punched Resident #161 in the left eye and right cheek when Resident #161 asked him to leave his room. A reasonable person (Resident #165) would not expect physical abuse from a roommate, and it would likely result in fear, insecurity, and anxiety. Resident #161 had a bruised eye, redness to his cheek and required neurological checks after the incident. Two of	F 600	The facility will continue to ensure that residents are free from resident-to-resident physical abuse. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice, 1) Residents #161, #164, and #165 no longer reside at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) Current residents have the potential to be affected. On 08/15/23, the Rehab Therapy Director and Administrative Nurses (the Director of Nursing, the wound care nurse, the MDS coordinator,	

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F 600	Continued From page 2	F 600		

three residents reviewed for abuse were affected by this deficient practice (Residents #164 and #161).

Immediate Jeopardy began on 4/5/2023 when the facility failed to protect Resident #165 from attempted choking. The immediate jeopardy was removed on 8/16/2023 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems that were put into place were effective.

Findings included:

1. Resident #164 was admitted to the facility on 3/7/2023 with diagnoses of encephalopathy and dementia with agitation.

On 3/9/2023 at 12:59 pm a Nurses Progress Note by Nurse #4 indicated Resident #164 had exit seeking behaviors and when attempting to redirect Resident #164 he had aggressive behaviors of leaning into nurse and gritting teeth. He told another staff member he should just smack someone. Nurse #4's Progress Note stated he was on one-to-one observations.

Resident #165 was admitted to the facility on 3/27/2023 with diagnoses of traumatic brain injury.

An admission Minimum Data Set (MDS) assessment dated 4/2/2023 indicated Resident #165 was cognitively intact and required supervision with bed mobility and transfers.

and Assistant Director of Nursing conducted interviews with all current residents that had a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. On 08/15/23, the Director of Nursing, the wound care nurse, the MDS coordinator, and assistant Director of Nursing conducted skin assessment on all current residents that had a BIMS of less than 13 to determine if there were any signs of Abuse. There were no issues identified. The Director of Nursing and the Regional Clinical Coordinator reviewed the electronic medical record dashboard on 8/15/23 for any documentation related to resident behaviors exhibited that would be indictive of potential abuse. There were no issues identified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur,

3) On 08/15/23 the Regional Clinical Coordinator educated the facility Administrator and Director of Nursing on the Abuse Policy and Procedure. The education emphasized the screenings for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education included the expectation that a routine review of the electronic medical record licensed nurse and nurse aide documentation would be conducted to identify residents that may be exhibiting behaviors indicative of

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F 600	Continued From page 3 On 4/6/2023 at 3:24 pm a late entry Nurse's Progress Note written by Nurse #10 for 4/5/2023 at 7:30 pm stated a Nurse Aide reported Resident #164 was lying on Resident #165's bed and threatened to choke his roommate. On 8/16/2023 at 11:42 am an interview was conducted with Resident #165 by phone about the incident on 4/5/23. Resident #165 stated he did not remember being at the facility and did not remember his roommate. Resident #165's Responsible Party was interviewed by phone on 8/16/2023 at 11:51 am and he stated Resident #165 had short- and long-term memory loss, due to his traumatic brain injury, and would not be able to remember anything that happened when he was at the facility. Nurse Aide (NA) #1 was interviewed by phone on 8/14/2023 at 6:57 pm. NA #1 stated she was in the hallway on 4/5/23 around 7:00 pm and heard Resident #165 yell, "Stop!". When she entered the room Resident #164 was on his knees on Resident #165's bed with his left arm around Resident #165's neck applying pressure and his right arm raised with his fist pointed at Resident #165's face like he was going to strike him. She stated she stopped Resident #164 before he struck Resident #165 in the face. NA #1 stated another Nurse Aide was assigned to Residents #164 and #165 at the time, but she did not remember who it was. NA #1 stated Resident #164 was on one-to-one observation at the time of the incident because of wandering and being aggressive and the Nurse Aide that was assigned to him should have been with him.	F 600	potentially abusive nature. The routine reviews will be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator, or MDS Coordinator. Interventions will be appropriately implemented implemented if such behaviors are identified, and any residents identified with potentially abusive behaviors will be referred to psych services. 100% of facility staff were in-serviced by the facility Administrator and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Wound care nurse, MDS Coordinator) on the facility's Abuse Policy and Procedure. The education emphasized the screening for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education also emphasized that any identified behaviors will be reported to the Administrator and/or Director of Nursing immediately and will have appropriate interventions implemented and those residents will be referred to psych services. This education began on 08.15.23 with no employee being allowed to work without receiving the education. All education was completed by 08.24.23. Newly hired employees that are hired after 08.24.23 will be in-serviced by the ADON on the facility's Abuse Policy and Procedure. The education will emphasize the screening for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education will	

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F 600	Continued From page 4 During a telephone interview with NA #2 on 8/15/2023 at 10:04 am she stated she worked on the 3:00 pm to 11:00 pm shift on 4/5/2023 when Resident #164 tried to choke Resident #165, but she was not aware of the incident until 4/6/2023. NA #2 stated Resident #164 was on one-to-one observation due to wandering and aggressive behaviors on 4/5/2023 but she did not remember who was assigned to do the one-to-one observation. On 8/15/2023 at 11:57 am a telephone interview was conducted with Nurse #10, and she stated one of the nurse aides, she did not remember which nurse aide, came up to her on 4/5/2023 on the 3:00 pm to 11:00 pm shift and told her Resident #164 had threatened to choke Resident #165, but no one told her that Resident #164 had put his hands on Resident #165. Nurse #10 stated Resident #164 was on one-to-one because the nurse aide told her Resident #164 put his hands on Resident #165's throat. Nurse #10 stated Resident #164 was not moved from Resident #165's room but Resident #164 was on one-to-one observation for the rest of the shift. Nurse #10 stated Resident #164 was on one-to-one observation because he had been exit seeking since he came to the facility. A summary of an investigation dated 4/11/2023 written by Director of Nursing (DON) #2 indicated Nurse Aide #1 told her on 4/6/2023 that on 4/5/2023 at approximately 7:20 pm Resident #164 was lying on Resident #165's bed and stated he was going to choke his roommate. DON #2 wrote Resident #164 was redirected without incident and remained on one-to-one observation throughout the night. The summary	F 600	also emphasize that any identified behaviors will be reported to the Administrator and/or Director of Nursing immediately and will have appropriate interventions implemented and those residents will be referred to psych services. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. 4) A QA monitoring tool will be utilized to ensure ongoing compliance by the RCC beginning on 9.6.23. The RCC will review facility resident interviews regarding abuse and facility electronic medical record dashboard reports weekly x 12 weeks to ensure that all allegations of abuse are reported to the Administrator or Director of Nursing immediately. Variances will be corrected at the time of review and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 9.13.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the September through November regularly	

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F 600	Continued From page 5 also indicated DON #2 assessed Resident #165 and there were no injuries and interviewed Resident #165 and Resident #165 stated Resident #164 put his hands up to his neck as if he was going to choke him, but staff came in and removed Resident #164 from his bed. During an interview with Director of Nursing (DON) #2 on 8/14/2023 at 2:43 pm she stated on the morning of 4/6/2023 Nurse Aide #1 told her Resident #164 attacked Resident #165 and she came to his aid before he could harm Resident #165. DON #2 stated she called Nurse #10, who had not reported the incident between Resident #164 and Resident #165 on 4/5/2023 at approximately 7:20 pm because the nurse was not aware Resident #164 had touched Resident #165. DON #2 stated when she spoke to Nurse #10, she stated Nurse Aide #1 told her she had intervened before Resident #164 had hurt Resident #165. The Police Department Dispatcher stated during a phone interview on 8/17/2023 at 2:11 pm that the police officer who spoke with the facility regarding Resident #165 being attacked by Resident #164 did not file a report, but he had put a note in the police log after he visited the facility. The Police Department Dispatcher stated no charges were filed regarding the incident on 4/5/2023. Resident #165 discharged from the facility on 5/18/2023. 2. Resident #161 was admitted to the facility on 4/24/2023 with diagnoses of dementia and weakness. On 4/24/2023 at 7:49 pm a progress note written by Nurse #5 indicated Resident #161	F 600	scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	

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was alert but confused about where he was. Nurse #5's progress note stated he was orientated to the facility, his room, his roommate, and the staff. An admission Minimum Data Set (MDS) assessment dated 4/30/2023 indicated Resident #161 was moderately cognitively impaired and required supervision with bed mobility and transfers.

A Nurse Progress Note by DON #2 written on 4/28/2023 at 5:44 pm stated Resident #164, had a history of exit seeking behaviors that turned into physically aggressive behaviors without being able to redirect on several occasions, and one on one observation was put into place to ensure his and other residents' safety. The note stated Resident #164 was taken off one-to-one observation since he had not had any agitation in the past two weeks.

On 5/3/2023 at 6:42 pm Nurse #15's Progress Note stated Resident #164 was swinging a back scratcher back and forth and then entered another resident's room. When trying to redirect Resident #164 with verbal cues and touching his arm he attempted to swing the back scratcher at Nurse #15.

On 5/4/2023 at 7:00 pm a Nurse's Progress Note written by Nurse #5 stated Resident #164 was attempting to exit a door to the outside and when unable to exit the door he entered Resident #161's room.

When Resident #161 asked him to get out of his room, Resident #165 swung and punched Resident #161 in the face. Resident #164 was immediately removed from the room and DON #2 was notified of the incident. Resident #161 who

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was on every 15-minute checks was placed back on one-to-one observation.

On 5/4/2023 at 6:30 pm Nurse #5 wrote a progress note that stated Resident #161 was found on the floor in his room on his bottom with his wheelchair behind him. The progress note further stated Resident #161 indicated Resident #164 entered his room and after he asked Resident #164 to leave, Resident #164 punched him in the left eye and right cheek, and he lost his balance and fell to the floor on his bottom.

Nurse #5's progress note stated Resident #164 was removed from Resident #161's room and Resident #161 was assessed for injuries. The progress note stated Resident #161 had a bruise to his left eye and slight redness to his right cheek.

On 5/18/2023 at 12:08 pm Nurse #5 was interviewed and stated Resident #164 would go into other residents' rooms and had aggressive outbursts. She stated Resident #164 had been on one-to-one observation for the wandering and aggressive outbursts, but they had taken him off of one-to-one observations and she did not remember why they had done so. Nurse #5 stated Resident # 164 was on every 15-minute checks. Nurse #5 stated Resident #161 had told Resident #164 to leave his room. Then Resident #164 hit Resident #161 in the left eye and right cheek and knocked him to the floor. She stated they did put Resident #161 on neurological checks. He did not complain about his eye hurting but his left eye was red and purplish, and his eye turned black the next day.

During an interview with Director of Nursing

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(DON) #2 on 8/14/2023 at 2:42 pm by phone she stated Resident #164 had another altercation with another resident, Resident #165, before he had the altercation with Resident #161. DON #2 stated Resident #164 was taken off one to one observation because he had gone a month without any issues with aggression and Nurse Practitioner #2, who was the Psychological Nurse Practitioner, had said it was okay to take him off the one-to-one observation. DON #2 also stated the Nurse Consultant had told her they could take Resident #164 off one-to-one observation since it had been almost 30 days since he had the altercation with Resident #165.

Nurse Practitioner (NP) #1 was interviewed by phone on 8/16/2023 at 2:50 pm and she stated she received a call on 8:20 pm on 5/4/2023 from Nurse #5 regarding Resident #164 punching another resident during an altercation but she did not remember any other details and she had not written down any details regarding the resident. She said she would have sent the resident to the emergency room for evaluation if she was told the resident's eye was bruising and his cheek was red.

During an interview with the Police Department Dispatcher on 8/17/2023 at 2:14 pm she stated an altercation was reported on 5/4/2023 but no charges were filed, and the officer did make a note in the log but there were no charges filed when the officer visited the facility.

On 8/16/2023 at 4:30 pm the Administrator was interviewed, and he stated Resident #164 had an altercation with Resident #165, who was his roommate, on 4/5/2023. He stated Resident #164 had not hit Resident #165 but had grabbed

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him and Nurse Aide (NA) #1 stopped Resident #164 before he could hurt Resident #165. The Administrator stated Resident #164 was put on one-to-one observations and Resident #165 was offered another room and was moved the next day. The Administrator stated Resident # 164 remained on one-to-one observation for a month and was on every 15-minute checks when a second incident occurred. The Administrator stated Resident #164 wandered into Resident #161's room and when Resident #161 asked him to leave Resident #164 hit Resident #161 in the face. The Administrator stated the facility had not done a formal plan of correction when either of the incidents happened.

Resident #161 discharged to his home on 5/18/2023.

The Administrator was notified of immediate jeopardy on 8/15/2023 at 6:56 pm.

Credible Allegation of IJ removal:
The Laurels of Salisbury wishes to have this submitted plan of immediate jeopardy removal stand as its written allegation of immediate jeopardy removal. Our alleged compliance is August 16, 2023.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

The jeopardous deficient practice resulted when it is alleged the facility failed to protect two residents from resident-to-resident abuse when resident #165 reported that resident #164 reached over and put his hands up to his neck as if he was going to choke him on 4/5/23. Resident

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#164 also allegedly punched resident #161 in the left eye and right cheek on 5/4/23 when resident #161 asked him to leave his room.

Resident to resident altercation 4.5.23 between resident #164 and resident #165

On the morning of 4.6.23 at 10:00am the Director of Nursing interviewed resident #165 who has a BIMS score of 12. Resident #165 reported to the Director of Nursing that resident #164 did walk to his side of the room and get on his bed the previous evening. Resident #165 reported that words were exchanged and resident #164 reached over and put his hands up to his neck as if he was going to choke him. Resident #165 called for help and reports the c n a immediately came in and removed resident #164 from his bed. Resident #164 continued 1:1 supervision overnight. The Director of Nursing examined resident #165 head and neck area on the morning of 4.6.23 and found no red marks, bruises, scratches, etc. Resident #165 denied any pain but stated he no longer wished to share a room with resident #164. Resident #165 was moved to another room and was satisfied with resolution. He was seen by the Nurse Practitioner after the incident and had no concerns.

Both resident's family members were notified as well as the physician.

The Salisbury Police Department was notified on 4.6.23 at 10:45am. Officer Johnson conducted an on-site visit and interviewed resident #165 who did not wish to press charges. The Rowan County DSS office was also notified on 4.6.23 but did not conduct an on-site visit or request any

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follow-up.
Other alert and oriented residents on the same hallway were interviewed by the Social Worker and Director of Nursing between 4.6.23 and 4.11.23 with no other concerns identified. Non alert and oriented residents on the same hallway had head to toe skin checks completed by the Director of Nursing between 4.6.23 and 4.11.23 with no concerns identified.

The Director of Nursing attempted to interview resident #164 on 4.6.23 but he did not recall the incident at all.

Resident #165 continued to receive staff support and had no concerns from time of incident until time of discharge 05/18.23. Resident #165 was discharged back to his previous care facility on 5.18.23 as a planned discharge.

Resident #164 remained on 1:1 supervision and discharge planning was in progress to locate appropriate placement closer to his family in Virginia. He did not have any further incidents and resident status was discussed with the physician and the Director of Nursing, and the decision to remove resident #164 from1:1 supervision was made, and he was removed from 1:1 supervision on 4/28/23.

Resident to resident altercation 5.4.23 between resident #164 and resident #161

On 5.4.23 at approximately 6:30pm staff noted resident #161 sitting on the floor of his room on his bottom, wheelchair behind him. He reported that resident #164 entered his room and attempted to sit on his bed. Resident #161 reports that he told resident #164 to leave his

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room. Resident #161 reported that resident #164 did not leave his room and he (resident #161) stood up from his wheelchair and walked towards resident #164 to tell him to leave his room. Resident #161 reports that resident #164 then proceeded to punch him in the left eye and right cheek. Resident #161 reports that he lost his balance and fell onto the floor. Resident #164 was immediately removed from resident #161's room by staff. The nurse assessed resident #161 and noted a bruised area to left eye noted and slight redness noted to right cheek. Both families were notified. The physician was notified, and neuro checks were implemented on resident #161. Law Enforcement and APS were notified. Residents on the same hallway as resident #164 were interviewed regarding potential abuse concerns with no negative findings by the Director of Nursing and Social Worker between 5.4.23 and 5.11.23. Resident #161 reported feeling safe within the facility.

Resident #164 was placed on 1:1 supervision immediately. Resident # 164 was discharged 5.17.23 to the hospital due to change in condition and did not return to the facility, therefore he did not pose a threat to any other residents in the facility.

Resident #161 was discharged home with home health and family support on 5.18.23 as a planned discharge.

Resident #164, resident # 165 and resident # 161 no longer reside at the facility.

To identify any other residents that may be affected by the same alleged deficient practice the following has occurred:

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On 08.15.23, the Rehab Therapy Director and Administrative Nurses (the Director of Nursing, the wound care nurse, the MDS coordinator, and Assistant Director of Nursing) conducted interviews with all residents that had a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues identified. Completed at 11:00pm.

On 08.15.23, the Director of Nursing, the wound care nurse, the MDS coordinator, and Assistant Director of Nursing conducted skin assessments on all the residents that had a BIMS of less than 13 to determine if there were any signs of abuse. Completed at 11:00pm.
None were identified.

The Director of Nursing and the Regional Clinical Coordinator reviewed the electronic medical record dashboard on 8.15.23 for any documentation related to behaviors exhibited that would be indictive of potential abuse, none were noted.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 08.15.23 the Regional Clinical Coordinator educated the facility administrator and Director of Nursing on the Abuse Policy and Procedure at 7:45pm. The education emphasized the screening for potentially abusive residents/guests through interview, observation and quarterly care conference reviews, as well as during care. The education included the expectation that a daily review (including holidays and weekends) of the

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electronic medical record licensed nurse and nurse aide documentation would be conducted to identify residents that may be exhibiting behaviors indictive of potentially abusive nature. The daily reviews will be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator, or MDS Coordinator. Interventions will be appropriately implemented if such behaviors are identified, and any residents identified with potentially abusive behaviors will be referred to psych services.

On 8.15.23 the facility Administrator and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Wound care nurse, MDS Coordinator) re-educated all staff in the facility on the facility's abuse policy and procedure. The education emphasized the screening for potentially abusive residents/guests through interview, observation, and quarterly care conference reviews, as well as during care. The education also emphasized that any identified behaviors will be reported to the Administrator and/or Director of Nursing immediately and will have appropriate interventions implemented and those residents will be referred to psych services.

All other employees will receive the same education prior to the start of their next scheduled shift. The administrator will monitor the staff to ensure that any staff that have not received the above education will receive stated education prior to working. The education will emphasize the screening for potentially abusive residents/guests through interview, observation, and quarterly care conference reviews, as well as during care. The education will also emphasize that any identified behaviors will be reported to the Administrator and/or Director of Nursing

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immediately and will have appropriate interventions implemented and those residents will be referred to psych services.

The facility alleges credible allegation of immediate jeopardy removal 08.16.23 The LNHA is responsible to implement the plan.

The credible allegation of immediate jeopardy removal was validated on 08/17/23.

The facility provided documentation of resident interviews with residents who were cognitively intact. Residents were asked if the staff treated them with dignity and respect; if anyone had ever abused them; and if they had any other issues with a staff member. A review of the interviews revealed the residents did not feel like they had been abused and they were treated with dignity and respect. The facility provided documentation of resident skin assessments for residents with residents who were not cognitively intact. The skin assessments did not reveal any injuries or bruising that would be consistent with abuse. The facility also reviewed all residents for behaviors that might cause injury or abuse to another resident. They identified two residents with behaviors: a resident who wandered, but was not combative, and a resident who had behaviors of kicking at staff but was not ambulatory and did not wheel herself in a wheelchair. Neither resident had a history of any behaviors against other residents. The interviews and skin assessments with staff were completed by 8/15/2023. The Regional Clinical Consultant provided education to the Administrator and the current Director of Nursing on Abuse Prohibition Policy. The facility provided in-service education on the Abuse Prohibition Policy to all staff by

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F 600	Continued From page 16 8/16/2023 and ensured any new staff would be educated regarding the Abuse Prohibition Policy before being allowed to work in the facility. A sample of residents were reviewed for any signs of abuse with no issues found. A sample of staff, including nursing, housekeeping, and therapy services were interviewed regarding the abuse education they received, and no issues were identified. The immediate jeopardy was removed on 8/16/2023.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of pain medication for 1 of 4 residents reviewed for abuse (Resident #211). The findings included: A physician order dated 11/4/2022 ordered to check the fentanyl patch (a narcotic pain medication that delivers medication through the skin over 72 hours for constant pain control) every shift and report placement to the oncoming shift.	F 602	Past noncompliance: no plan of correction required.	

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A review of the medication administration record (MAR) revealed that the fentanyl patch had been documented on by nursing each shift for the period of 11/4/2022 through 11/30/2022.

A physician order dated 11/5/2022 ordered fentanyl patch 100 micrograms (mcg) per hour, apply one patch every 72 hours, remove the old patch prior to reapplying. This order was discontinued on 11/11/2022.

A nursing note dated 11/10/2022 written by Nurse #1 documented Resident #211's fentanyl patch was on at shift change and hourly checks were conducted until 6:00 PM and the next time Nurse #1 was able to check Resident #211, it was almost 9:00 PM. The note documented that the bedding and Resident #211's clothing were checked for the patch, and it was not found. The note documented the Director of Nursing (DON) #3 was notified, as well as the provider.

A nurse practitioner (NP) note dated 11/11/2022 documented that Resident #211 had chronic lower back pain and she was on a fentanyl patch and as needed hydrocodone/acetaminophen. The note documented the fentanyl patch was discovered missing on 11/10/2022 and hydrocodone/acetaminophen was ordered for pain control until the patch could be reapplied. The NP documented that Resident #211 denied pain during the NP assessment. The note documented a new order for fentanyl patch and other medications for pain control. The note further documented an order to check the patch placement each shift and report the placement to the on-coming shift.

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An order dated 11/11/2022 ordered fentanyl patch 100 mcg per hour to be applied every 72 hours, remove the old patch prior to reapplying the new patch.

Review of Nurse #9's employment record revealed she had been hired on 11/2/2022 and no issues were identified with her background check, reference check, or license check. Drug screening performed prior to hire was negative. Nurse #9 completed facility orientation on 11/2/2022 and was with a preceptor on 11/4/2022, 11/5/2022, 11/6/2022, 11/7/2022 and 11/9/2022 and was given an independent assignment on 11/10/2022.

Review of the assignment sheets for 11/10/2022 and 11/11/2022 revealed Nurse #9 was not assigned to Resident #211.
Nurse #9 was not available for interview.

Nurse #1 was interviewed on 8/17/2023 at 6:33 PM by phone and she reported she was working evening shift when Resident #211's fentanyl patch was discovered missing. Nurse #1 reported the first time the patch was gone from Resident #211, the resident had received a shower and when she returned, the patch was noticed to be missing. Nurse #1 explained that she and the nursing assistant (NA) searched the resident's bed linens and dirty clothing, but they were unable to locate the patch. The nurse reported she called DON #3 and reported the missing patch, called the provider, and received an order to replace the patch. Nurse #1 was not certain of the exact dates or times. Nurse #1 explained a day or two later, the patch was missing from Resident #211 again and she called DON #3 and the provider and received an order to apply another patch and

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to document hourly the placement. Nurse #1 reported Nurse #9 was working on a different hall that evening. Nurse #1 reported that the next evening (11/10/2022), the patch was missing from Resident #211. Nurse #1 said that she had checked the patch placement hourly until 6:00 PM and she got busy with passing medications and resident care. Nurse #1 reported after supper (uncertain of the exact time), she went in to check for the fentanyl patch placement and the patch was gone. Nurse #1 explained she asked Resident #211's roommate if anyone had been in the room and the roommate reported that a nurse had come into the room after supper and was "messing with" Resident #211. The roommate provided a physical description of the nurse. Nurse #1 described asking Nurse #9 to assist with repositioning Resident #211. The roommate confirmed that Nurse #9 was the nurse who came in and "messed with" Resident #211. Nurse #1 reported she questioned Nurse #9 about coming into the resident's room and Nurse #9 said she had picked up the supper tray from Resident #211. Nurse #1 reported she called the DON #3 with her observations, and the DON #3 interviewed Nurse #9 and was told the same story. Nurse #1 reported Nurse #9 was suspended and she was not certain what happened after that. Nurse #1 described providing Resident #211 with a pain assessment and oral pain medication during her shift and that Resident #211's pain level was controlled by the oral medications. Nurse #1 reported she received education related to checking the placement of fentanyl patches and documentation related to checking the placement.

DON #3 was interviewed by phone on 8/21/2023 at 8:33 AM. DON #3 explained she was the

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Director of Nursing at the facility from August 2022 until December 2022. DON #3 reported she was notified of the missing fentanyl patch by Nurse #1 each time the patch was missing. DON #3 explained during the hiring process for Nurse #9 nothing came back that was concerning. Nurse #9 had a drug screen that was negative, her background check and reference check was fine, and no issues were identified on her license. DON #3 explained she was notified of the missing fentanyl patch on 11/6/2022 and because Resident #211 had just gotten a shower, they thought the patch might have dropped off and was missing, there was no reason to suspect anyone had taken the patch off at that time. DON #3 said that the 2nd incident occurred on 11/9/2022 and that's when she started looking at who was working and what was happening in the facility, and she asked Nurse #1 to check the patch placement hourly and to report to the other shifts to do the same until she came in the next day. DON #3 reported on 11/10/2022 the patch was missing from Resident #211 again and that's when she started a full investigation and consulted with the regional nursing consultant to determine the next course of action. DON #3 reported she interviewed Nurse #9 and was told that Nurse #9 was in Resident #211's room (not her assignment) to pick up the supper tray. DON #3 suspended Nurse #9 pending drug screening results. DON #3 reported Nurse #9 told her she was going out of town and couldn't get a drug screening for several days, and then changed her story multiple times over the next few days. DON #3 reported that Nurse #9 attempted to have a drug screen completed on 11/12/2022 but refused to submit to a witnessed urine collection and left the testing site. Nurse #9 had a rapid urine test on 11/14/2022 and the results were inconclusive,

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and the sample was sent for further testing, which did return positive for fentanyl. Nurse #9 was terminated from her position at the facility and the Board of Nursing was notified of the incident.
DON #3 reported she implemented a plan of correction immediately which included an audit of all residents who were prescribed a fentanyl patch (one other resident, in addition to Resident #211) and gave education to all staff. Interviews were conducted with alert and oriented residents regarding staff taking their medications and no issues were identified by those interviews. Resident #211 was assessed for pain and provided oral pain medications during the time the fentanyl patch was not applied to her. DON #3 reported that no other issues of medication misappropriation had occurred while she was the DON.

The Administrator was interviewed on 8/18/2023 at 11:02 AM by phone. The Administrator reported that during the hiring process of Nurse #9, nothing concerning came up with her background check, references, or drug screen. The Administrator reported DON #3 developed a plan of correction and implemented it to prevent further incidents of medication misappropriation from the residents.
The facility's plan of correction dated 11/12/2022 was reviewed. Included was identifying the issue (missing fentanyl patches applied to a resident), identifying who this could impact (other residents with fentanyl patches). The facility conducted a 100% audit of all residents and only one other resident was prescribed fentanyl patch. The narcotic records were audited, and no discrepancies were identified. The pharmacy consultant also audited the narcotic records, and no issues were identified. The interdisciplinary

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team reviewed the MARs daily in the clinical morning meeting for all residents with orders for fentanyl patches to ensure correct documentation and notation of the placement of the patch. Education was provided to all nursing staff related to fentanyl patches, application, documentation, and checking placement. The DON was responsible for reviewing the audits weekly and reporting the findings to the Administrator, and to the Quality Assurance committee monthly.

The plan of correction was validated by reviewing the audits completed by the facility on 8/16/2023. No current residents were prescribed fentanyl patches during the survey. Narcotic sheets were reviewed, and no issues were identified with the documentation. During the survey, alert and oriented residents were interviewed and no resident expressed concerns related to misappropriation of medications.

Nurse #2 was interviewed on 8/15/2023 at 11:39 AM. Nurse #2 reported she had provided care to Resident #211, and she was aware of the fentanyl patch missing from the resident after the incident. Nurse #2 reported she received education and in-services related to medication diversion and checking the placement of fentanyl patches.

Nurse #4 was interviewed on 8/15/2023 at 12:26 PM by phone. Nurse #4 reported she was not aware of the missing fentanyl patch until after the incident. Nurse #4 explained that any resident prescribed a fentanyl patch requires the nurse to check the placement at the change of shift to confirm placement and then the placement is reported to the oncoming nurse.

Nurse #5 was interviewed on 8/15/2023 at 2:17

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F 602	Continued From page 23 PM. Nurse #5 reported she had not been assigned to Resident #211, but she received education regarding checking placement for the fentanyl patches on any resident who had that medication ordered. An interview was conducted with Nurse #6 on 8/15/2023 at 5:32 PM. Nurse #6 reported she had received education related to fentanyl patches and checking the placement, as well as documentation in the MAR related to the placement. The plan of correction had a completion date of 11/12/2022.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607		9/11/23

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F 607	Continued From page 24 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy for reporting when the Nurse did not notify the Administrator or Director of Nursing when resident to resident abuse was reported to her by the Nurse Aide. On 4/5/2023 Resident #164 was observed by the Nurse Aide on his knees on Resident #165's bed with his left arm around Resident #165's neck, in a choke hold and his right arm raised like he was going to strike Resident #165 in the face. This deficient practice occurred for 1 of 2 residents reviewed for resident-to-resident abuse. Findings included: The facility's Abuse Prohibition Policy which was last revised on 9/9/2022 stated the staff will report any allegations or suspicions of abuse to the Administrator and Director of Nursing immediately and the Administrator or designee will notify the State agency per state guidelines. Resident #165 was admitted to the facility on 3/27/2023 with diagnoses of traumatic brain injury due to a fall. An admission Minimum Data Set (MDS)	F 607	The facility will continue to ensure that the abuse policy for reporting allegations of abuse to the Administrator or Director of Nursing is implemented. Address how corrective actions will be accomplished for those residents found to have been affected by the deficient practice, 1) Residents #161, #164, and #165 no longer reside at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) Current residents involved in abuse allegations have the potential to be affected. On 08.15.23, the Rehab Therapy Director and Administrative Nurses (the Director of Nursing, the wound care nurse, the MDS coordinator, and Assistant Director of Nursing) conducted interviews with all current residents that had a BIMS of 13 or greater (cognitively intact) to determine if they felt safe in the facility. There were no issues	

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F 607	Continued From page 25 assessment dated 4/2/2023 indicated Resident #165 was moderately cognitively impaired and required supervision with transfers. Resident #164 admitted to the facility on 3/7/2023 with diagnoses of dementia with agitation and encephalopathy. An admission Minimum Data Set (MDS) assessment dated 3/13/2023 indicated Resident #164 was moderately cognitively impaired and required supervision with transfers and ambulation. Nurse Aide (NA) #1 was interviewed by phone on 8/14/2023 at 6:57 pm and stated on 4/5/2023 around 7:20 pm she was in the hallway and heard Resident #165 yell "stop". NA #1 stated when she entered the room Resident #164 was on his knees on Resident #165's bed with his left arm around Resident #165's neck in a choke hold, applying pressure, and his right arm raised in a fist pointing at Resident #165's face, like he was going to hit him. NA #1 stated she removed Resident #164 from the room; told Nurse #10 that Resident #164 had Resident #165 in a headlock with his left arm and his right arm raised like he was going to strike him with his fist when she stopped him; and Resident #164 was on 1 to 1 observation continuously for the rest of her shift. On 4/6/2023 at 3:24 pm Nurse #10 wrote a Progress Note that was a late entry note for 4/5/2023 at 7:20 pm, which stated the Nurse Aide reported Resident #164 was lying on his roommate's (Resident #165) bed and threatened to choke Resident #165 approximately one hour earlier. Resident #164 was medicated, and the medication had calmed Resident #164.	F 607	identified. On 08.15.23, the Director of Nursing, the wound care nurse, the MDS coordinator, and Assistant Director of Nursing conducted skin assessments on all current residents that had a BIMS of less than 13 to determine if there were any signs of abuse. There were no issues identified. The Director of Nursing and the Regional Clinical Coordinator reviewed the electronic medical record dashboard on 8.15.23 for any documentation related to resident behaviors exhibited that would be indictive of potential abuse. There were no issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, 3) On 08.15.23 the Regional Clinical Coordinator educated the facility Administrator and Director of Nursing on the Abuse Policy and Procedure. The education emphasized the screening for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education included the expectation that a routine review of the electronic medical record licensed nurse and nurse aide documentation would be conducted to identify residents that may be exhibiting behaviors indicative of potentially abusive nature. The routine reviews will be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator, or MDS Coordinator.	

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F 607	Continued From page 26 On 8/15/2023 at 11:57 am a telephone interview was conducted with Nurse #10, and she stated one of the nurse aides, she did not remember which nurse aide, came up to her on 4/5/2023 on the 3:00 pm to 11:00 pm shift and told her Resident #164 had threatened to choke Resident #165, but no one told her that Resident #164 had put his hands on Resident #165. She stated she would have called the Director of Nursing if she was aware Resident #164 had put his hands on Resident #165. Nurse #10 stated the next day, 4/6/2023, DON #2 called her and asked what had happened because the nurse aide told her Resident #164 put his hands on Resident #165's throat. During an interview with Director of Nursing (DON) #2 on 8/14/2023 at 2:43 pm she stated on the morning of 4/6/2023 Nurse Aide #1 told her Resident #164 attacked Resident #165 on 4/5/2023, and she came to his aid before he could harm Resident #165. DON #2 stated she called Nurse #10 and she had not reported the incident between Resident #164 and Resident because Nurse #10 was not aware Resident #164 had touched Resident #165. DON #2 stated when she spoke to Nurse #10, she stated Nurse Aide #1 told her she had intervened before Resident #164 had hurt Resident #165. DON #2 stated Nurse #10 thought since Nurse Aide #1 had stopped Resident #164 so there was no need to report the incident to DON #2. DON #2 stated the incident should have been reported to her on 4/5/2023 at approximately 7:20 pm when it happened. During an interview with the Administrator on 8/16/2023 at 4:30 pm he stated he was not aware	F 607	Interventions will be appropriately implemented if such behaviors are identified, and any residents identified with potentially abusive behaviors will be referred to psych services. 100% of facility staff were in-serviced by the facility Administrator and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Wound care nurse, MDS Coordinator) on the facility's Abuse Policy and Procedure. The education emphasized the screening for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education also emphasized that any identified behaviors will be reported to the Administrator and/or Director of Nursing immediately and will have appropriate interventions implemented and those residents will be referred to psych services. This education began on 08.15.23 with no employee being allowed to work without receiving the education. All education was completed by 08.24.23. Newly hired employees that are hired after 08.24.23 will be in-serviced by the ADON on the facility's Abuse Policy and Procedure. The education will emphasize the screening for potentially abusive residents through interview, observation, and quarterly care conference reviews, as well as during care. The education will also emphasize that any identified behaviors will be reported to the Administrator and/or Director of Nursing immediately and will have appropriate interventions implemented and those	

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F 607	Continued From page 27 Nurse #10 had not reported the altercation to DON #2 when it happened on 4/5/2023. The Administrator stated it should have been reported to him, the Responsible Party and DON #2 immediately.	F 607	residents will be referred to psych services. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. 4) A QA monitoring tool will be utilized to ensure ongoing compliance by the RCC beginning on 9.6.23. The RCC will review facility resident interviews regarding abuse and facility electronic medical record dashboard reports weekly x 12 weeks to ensure that all allegations of abuse are reported to the Administrator or Director of Nursing immediately. Variances will be corrected at the time of review and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months beginning on 9.13.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months during the September through November regularly scheduled meetings or until resolved and additional education/training will be provided for any issues identified.	
F 684 SS=D	Quality of Care	F 684		9/11/23

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F 684	Continued From page 28 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, vascular wound Nurse Practitioner (NP) and Physician interviews, the facility failed to clarify and document surgical wound care and wound vac (a device used to remove pressure and fluids from a wound) orders for 1 of 1residents reviewed for surgical wound care (Resident #217). Findings included: Resident #217 was admitted to the facility on 6/28/23 with diagnoses that included Peripheral Vascular Disease (PVD), total occlusion of lower leg arteries, total occlusion of arteries of the lower extremities and tobacco use. He was discharged to the hospital on 7/12/23. A review of a hospital discharge summary dated 6/28/23 at 12:32 PM revealed in part Resident #217 was admitted to the hospital from the vascular clinic on 6/12/23 when a noninvasive test revealed minimal to no blood flow of both lower legs. On 6/15/23 Resident #217 underwent a left femoral popliteal bypass procedure (a graft is placed in the lower leg to create a new blood	F 684	1) Resident #217 was seen at wound care clinic for surgical wound and then discharged to acute care setting. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) On 8.7.2023 the Director of Nursing and nursing staff completed and documented head to toe skin assessments on current residents. All surgical wound care orders were clarified with the provider and no other residents were found to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, 3) By 9.6.2023 education to the Director of Nursing, wound care nurse, and nurse manager was completed by the Regional Clinical Consultant on clarifying and documenting surgical wound care orders and wound vac orders. All licensed nurses were educated on 9.6.2023 on the skin management policy. The Director of Nursing will discuss current residents with	

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F 684	Continued From page 29 flow path to replace a damaged artery).Due to poor wound healing, on 6/27/23 a wound vac (a device used to remove pressure and fluids from a wound) was placed over the distal portion of the left leg surgical wound surgical wound behind the left knee. On 6/28/23 the wound vac was removed from the left leg surgical wound for transport to the facility. The wound measured 3.5cm (centimeter) x 1cm, a normal saline wet to dry dressing was placed over the incision. When Resident #217 arrived at the facility wound care instructions were to cleanse the left knee surgical site with anasept wound cleanser, pack with wet gauze, cover with black foam and apply the wound vac with continuous pressure of 125mmHg (millimeters). The surgeon was to be notified if the wound became red, opened, or began to drain. An admission Minimum Data set (MDS) dated 7/03/23 reveled Resident #217 had no cognitive impairment and coded to have no behaviors. He required limited or extensive assistance for most activities of daily living. He was admitted with 1 venous/arterial wound and surgical wounds on admission and required surgical and non-surgical wound care. A review of a Nurse note titled 24-hour skin assessment dated 6/29/23 at 3:08 PM for Resident #217 revealed in part the Wound Care Nurse observed Resident #217's skin to be mainly clear, dry and intact. A wound vac was removed the surgical incision measured 14 cm(centimeters) with 9 sutures. The wound site was red, warm to touch with an opening identified at the distal end of the suture line. Review of a care plan initiated 6/29/23 revealed	F 684	surgical wounds or wound vacs in weekly clinical operations meetings as well as address any newly admitted residents with these orders. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. 4) The Director of Nursing will complete a monthly assessment for three (3) months for sustained compliance. The Director of Nursing will assess clarification and documentation of all surgical wound and wound vac orders for 3x/weekly x 4 weeks; 2x/weekly x 4weeks; and then weekly x4 weeks. Continued compliance will be monitored through the facilities Quality Assurance and Process Improvement Program for 3 months and any concerns will be addressed by the Regional Clinical Consultant. Date of compliance will be 9.11.2023.	

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Resident #217 had actual impaired skin integrity related to a surgical wound with the goal that Resident #217 would have no complications of the surgical wound through the next review date. Interventions included in part to encourage good nutrition; report wound abnormalities to the physician (MD).

Review of the 6/2023 Treatment Administration Record (TAR) for Resident #217 revealed no wound treatment orders recorded from 6/28/23 through 6/30/23. There was no documentation of wound care provided again until 7/03/23.

On 8/16/23 at 4:43 PM the Wound Care Nurse was interviewed and revealed she was aware Resident #217 had a wound vac to the right leg on with a wound vac on admission. She revealed the seal of the wound vac often became dislodged and the nurses had to reseal it multiple times. The Wound Care Nurse revealed she performed complete head to toe skin assessment on Resident #217 within 24 hours of admission. During the assessment she removed the wound vac and dressing. She applied a new wound dressing and replaced the wound vac. During the interview, the Wound Care Nurse was not able to recall the exact wound care orders or wound vac settings and revealed she documented her assessment on the 24 - hour admission form not on the TAR.

An MD order dated 7/02/23 included to apply the wound vac to Resident #217's left lower leg surgical line, cleanse with normal saline solution, pat dry, apply skin prep to the per-wound (skin surrounding edges of the wound) bed, apply 1 black foam piece cut to fit the open wound and 1 long strip contact layer along the suture line with

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seal achieved at 125mmHg. Change three times weekly on Monday, Wednesday, and Friday.

Review of the TAR dated 7/2023 for Resident #217 revealed an MD order dated 7/02/23 was transcribed which included wound care and wound vac settings to begin on 7/03/23. The treatment and wound vac settings were recorded completed on 7/03/23, 7/05/23 and 7/12/23.

An MD history and physical note dated 7/04/23 revealed in part Resident #217 experienced slow wound healing and incisional breakdown of the surgical wound that required an excisional debridement at the hospital and a wound vac was applied to the right calf surgical wound on 6/27/23.

A Nurse note dated 7/12/23 at 4:14PM revealed Resident #217 was transported to his post-surgical MD visit; The Nurse received a phone call from the facility transporter and was informed Resident # 217 was being admitted to the hospital for a possible wound infection.

On 8/17/23 at 11:40 PM the Wound Care nurse was reinterviewed. She revealed she was not responsible to transcribe wound orders for residents the date of admission, but usually reviewed the MD orders and TARs within 24 hours of admission. The Wound Care Nurse was not able to explain why there was no record of skin treatments or care of the wound vac for Resident #217 until about 7/01/23 or 7/02/23 when the MD reordered the treatments for the entire month and treatments ordered were initiated on 7/03/23. The Wound Care Nurse revealed the facility did not have standing orders for wound care and the wound care service did

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not manage surgical wounds, so she used the protocol she had previously used for wound vac management which was to apply continued pressure at 125mmHg. She responded that she could not explain why Resident #217's admission wound care orders from the surgeon were not recorded and she could not locate them to review. She revealed she did not notify the surgeon or MD of her assessment on 6/29/23. The Wound Care Nurse clarified the wound vac was to the back of Resident #217's left knee.

On 08/17/23 at 2:11 PM a phone interview was conducted with the facility MD. He revealed he did not examine the wound vac or wound care orders for Resident #217 because the wound care group and nursing staff were responsible to manage wound care. The MD revealed he was not aware that the wound care group that came to the facility weekly did not manage surgical wounds, however he did review wound care orders on 7/02/23 and reordered them per hospital discharge orders.

A phone interview was conducted on 8/17/23 at 10:14 AM with the NP from the vascular clinic. The NP explained that Resident #217 had an extensive history of lower extremity arterial and venous flow of both legs, and he was noncompliant with care as an outpatient and continued to smoke heavily. She went on to explain when Resident #217 was discharged to the facility on 6/28/23 he had specific orders for wound care that included to maintain the wound vac with continuous suction of 125mmHG and wound care to be completed every Monday, Wednesday, and Friday. A review of the 6/28/23 discharge orders to the facility were reviewed with the NP . The NP explained the vascular clinic

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F 684	Continued From page 33 wrote very specific post operative wound care and thorough wound vac orders, but she was not able to explain why the orders were missed by the facility. The NP revealed the vascular center had not received any communication from the facility staff to report changes in wound care status or wound vac concerns. The NP also revealed that when Resident #217 was brought to the vascular clinic on 7/12/23 for his scheduled post operative appointment the left leg surgical incision was red, inflamed and had an open area with drainage at the distal end. The NP revealed Resident #217 was readmitted to the hospital from the vascular clinic and underwent a left above the knee amputation. She stated that the vascular team had previously determined that Resident #217 would require the amputation in the future, but hoped placement at the facility would delay an amputation. The NP revealed she did not believe care provided by the facility was the cause of the amputation because even if he had discharged home, remained at an acute care facility, or went to another facility for rehab the outcome would have remained the same. A phone interview conducted with the Director of Nurses (DON) on 8/17/23 at 3:00PM revealed al new residents with wound care orders were to be checked by a second Nurse, then sent to the MD for review and verification of wound care orders prior to the wound care orders being transcribed and initiated as per the MD plan of care.	F 684		
F 761 SS=D	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	F 761		

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F 761	Continued From page 34 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to store narcotic pain medications in a locked compartment in 1 of 1 medication rooms. The findings included: A facility reported investigation report dated 2/21/2023 documented 5 oxycodone/acetaminophen tablets were missing from the medication room. The medications had been delivered to the facility and were left on the counter of the medication room. The report documented the facility became aware of the missing medications on 2/13/2023 at 1:30 PM.	F 761	Past noncompliance: no plan of correction required.	

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No residents were affected by the missing medications.

The report read, in part:
On 2/6/2023 an order was placed by the Director of Nursing (DON) #2 to replenish emergency narcotic medications for the automated medication dispensing cabinet, including 5 tablets of oxycodone immediate release 5 milligrams (mg); 10 tablets of hydrocodone/acetaminophen 5/325 mg; and 5 tablets of oxycodone/acetaminophen 5/325 mg.

The medications were delivered on 2/7/2023 between 5:00 PM and 6:00 PM and signed for by Nurse #7. The medications were placed on the counter in the locked medication room.

DON #2 was out sick from 2/8/2023 to 2/10/2023 and unable to place the medications into the automated medication dispensing cabinet and the medications remained on the counter in the locked medication room. The facility nursing staff did not lock the medications into the automated medication dispensing cabinet.

On 2/11/2023 Nurse #8 (the assistant Director of Nursing at the time) called DON #2 regarding the medications and attempted to restock the medications into the automated medication dispensing cabinet, but reported the codes were incorrect and the automated medication dispensing cabinet would not accept the codes. Nurse #8 did not successfully add the medications to the automated medication dispensing cabinet and the medications remained on the counter in the locked medication room.

DON #2 returned to the facility on 2/13/2023 and

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requested new codes for the medications to restock the automated medication dispensing cabinet. Upon requesting the new codes, DON #2 discovered the 5 tablets of oxycodone/acetaminophen were not in the package of medications. DON #2 conducted interviews with all staff who were scheduled to work and none of the nurses could recall seeing the package of medications on the counter in the locked medication room.

Drug screens were ordered for all nursing staff scheduled at the facility from 2/7/2023 to 2/13/2023 and all were negative for oxycodone. Two nurses did not have a drug screen completed; one nurse was out on medical leave, and the second nurse refused to have a drug screen and quit without notice.

The facility notified the Police Department and the Board of Nursing. Education was provided to nursing staff regarding securing any medications delivered to the facility in a locked narcotic drawer until the medication could be placed in the automated medication dispensing cabinet.

The facility medication room was observed on 8/15/2023 at 11:38 AM. The door to the medication room was locked. There were no medications noted on the counter. The refrigerator was locked. The automated medication dispensing cabinet was accessible only by individual passcodes. No issues were identified during the observation. An observation was conducted of 3 of the 4 medication carts (100-hall, 200-hall, and 300-hall) and no issues were identified.

An interview was conducted with Nurse #8 on

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8/15/2023 at 11:17 AM. Nurse #8 reported that she was the Assistant DON from January 2023 until the end of February 2023 and was working when the oxycodone/acetaminophen tablets were missing. Nurse #8 explained that narcotics were delivered to the facility in an unmarked bag and placed on the counter in the medication room because she did not have access to the automated medication dispensing cabinet and the DON was out sick. Nurse #8 reported that after the medications were missing, they decided that any medications delivered for restocking the automated medication dispensing cabinet that could not be added to the machine right away would be locked in the 200-hall narcotic drawer until the DON was able to restock the automated medication dispensing cabinet. Nurse #8 reported she participated in auditing the medication carts for correct storage and labeling and the facility continued to have the pharmacist conduct monthly audits. Nurse #8 reported she submitted a random drug screen.

Nurse #7 and DON #2 were not available for interviews.

The facility's plan of correction dated 2/16/2023 was reviewed. Included was identifying the issue (controlled narcotic medications were not verified, accounted for, and maintained in the appropriate/designated double-locked storage). The facility conducted a 100% audit of all medication labeling and storage. An auditing tool was developed to weekly monitor the medication room and the medication carts for correct storage and labeling. These audits were completed 5/22/2023. Education was provided to all licensed nursing personnel regarding controlled narcotics and the storage. The automated

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medication dispensing cabinet representative conducted an in-service for all nursing personnel regarding controlled narcotics and medication storage. The automated medication dispensing cabinet representative conducted an audit of the automated medication dispensing cabinet on 2/28/2023. The DON reviewed the audits weekly and the findings were reported to the administrator. The findings were taken to the monthly Quality Assurance meeting.

The plan of correction was validated on 8/17/2023 by reviewing the audits completed by the facility, reviewing education provided to nursing staff, observations of the medication room and 3 of 4 medication carts, and nursing staff interviews.

Nurse #2 was interviewed on 8/15/2023 at 11:39 AM. Nurse #2 reported she received education regarding medication deliveries from the pharmacy and locking those medications into the narcotic drawer of the 200-hall medication cart, if the DON was not available to put the medications into the automated medication dispensing cabinet. Nurse #2 reported she submitted a random drug screen.
Nurse #4 was interviewed on 8/15/2023 at 12:26 PM by phone. Nurse #4 reported she remembered the package of medication on the counter in the medication room, but the package was not labeled and there was no way to see what was in the package. Nurse #4 reported if medications were delivered to the facility and the DON was not available, they locked the medications into the 200-hall narcotic drawer. Nurse #4 reported she submitted a random drug screen.

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Nurse #3 was interviewed on 8/15/2023 at 5:06 PM. Nurse #3 reported she received education related to the storage of controlled medications. Nurse #3 explained that medication that were delivered to the facility for restocking the automated medication dispensing cabinet were placed in the 200-hall narcotic drawer until the DON could place the medications into the automated medication dispensing cabinet. Nurse #3 reported she submitted a random drug screen.

Nurse #5 was interviewed on 8/15/2023 at 2:17 PM. Nurse #5 reported she submitted a random drug screen. Nurse #5 explained that if the DON was not available to lock medications into the automated medication dispensing cabinet, those medications were locked in the narcotic drawer of the 200-hall medication cart.

An interview was conducted with Nurse #6 on 8/15/2023 at 5:32 PM. Nurse #6 reported she had received education related to receiving medications from the pharmacy that were to restock the automated medication dispensing cabinet. Nurse #6 reported if the DON was not available to put the medications into the automated medication dispensing cabinet, she put the medications into the locked narcotic drawer in the 200-hall medication cart. Nurse #6 reported she submitted a random drug screen.

DON #1 was interviewed on 8/17/2023 at 3:57 PM. DON #1 reported she had been in the position of DON for just a few weeks and the missing oxycodone/acetaminophen happened before she started in the position. DON #1 reported that when she started her position, a plan of correction was in place related to receiving, storage, and labeling of controlled

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F 761	Continued From page 40 medications. DON #1 explained that she had a code for the automated medication dispensing cabinet, and she was able to add medications to the cabinet, but if medications were delivered when she was not in the building, those medications should be placed in the locked narcotic drawer of the 200-hall medication cart. DON #1 explained that monthly the pharmacist would audit the medication room and the medication carts and she and the Assistant DON were conducting random audits to ensure medication was stored and labeled correctly. DON #1 further explained that she also reviewed the medication delivery slips and matched to the orders placed and the medications delivered to the facility. The Administrator was interviewed on 8/18/2023 at 11:02 AM by phone. The Administrator reported DON #2 developed a plan of correction and implemented it to prevent further incidents of medication misappropriation from the facility. The plan of correction had a completion date of 5/22/2023.	F 761		
F 803 SS=F	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;	F 803		9/11/23

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F 803	Continued From page 41 §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 observation of the lunch meal tray line observation, staff interviews, and record review the facility failed to provide portions of food per the menu which had the potential to affect all 56 residents in the facility since there were no residents that did not receive a meal tray. Findings included: The menu for Sunday, 8/13/2023, for the lunch meal trays for all regular, Mechanical Soft, and Pureed Diets consisted of: 3 ounces of Salisbury steak; 4 ounces of potatoes; 4 ounces of spinach; 1 dinner roll; and 1 slice of chocolate pie. During a continuous observation of the lunch meal tray line on 8/13/2023 from 11:34 am until 1:07 pm the Cook used: a blue handled scoop (2 ounces) in the mechanical soft meat (the menu called for 3 ounces); a blue handled scoop in the creamed potatoes (the menu called for a 4	F 803	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice, 1) On 8.13.2023 the Dietary Manager educated dietary staff on the proper utensils for use in providing adequate portions to all residents. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) This deficient practice had the potential to affect food served to all residents. No other concerns were identified during subsequent observations. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, 3) The Dietary Manager will educate all dietary staff on the company's policy of	

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F 803	Continued From page 42 ounces); a green handled scoop (3 ounces) in the puree meat (the menu called for 3 ounces); a green handled scoop (3 ounces) in the pureed spinach (the menu called for 4 ounces); and a grey handle slotted spoon (1 cup) in the regular texture spinach (the menu called for 4 ounces). The Cook was interviewed on 8/13/2023 at 1:08 pm after she completed serving all trays and the wrong scoops and slotted spoon was used for the portion sizes on the menu. The Cook stated she did not know what sizes of the scoops, or the grey handle slotted spoon she should have used, and she would need to ask the dietary manager. On 8/13/2023 at 2:31 pm a follow up interview was conducted with the Cook, and she stated she had worked at the facility for 1.5 years and the slotted spoon and the scoops are the ones that she was trained to use, and she had always used them as she had when the tray line was observed. During an interview with the Dietary Manager on 8/15/2023 at 11:17 am he stated the Cook was not the facility's full-time cook and he was not sure why she was using the wrong scoops and slotted spoon during the lunch tray line observation on 8/13/2023 except that staff sometimes did things the way they wanted instead of the way it should be done. The Dietary Manager stated the Cook told him she used the wrong scoops and slotted spoon. On 3/16/2023 at 4:30 pm an interview was conducted with the Administrator, and he stated he was surprised the Cook had used the wrong size scoops and slotted spoon when serving the lunch meal during the observation of the lunch	F 803	portion servings by 9.06.23. This education will be included in onboarding new dietary staff hired after 9.06.23. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. 4) Dietary Manager will utilize a Quality Assurance monitoring tool to inspect proper portions are being served to residents during meal times Beginning on 9.07.23. This monitoring will be completed 5 times per week for 4 weeks and then 3 times per week for 4 weeks and then weekly for 4 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Continued compliance will be monitored through the facilities Quality Assurance and Process Improvement Program for 3 months. Date of compliance will be 9.11.2023.	

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F 803	Continued From page 43 tray line observation on 8/13/2023. He stated the Cook was not the facility's full time cook but she had worked in food service for many years and should have known better. The Administrator stated the Cook should have used the correct size utensils to ensure the residents received the correct portion to ensure their nutritional needs are met.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation of the lunch tray line; staff interviews, and record review the facility staff failed to ensure the thermometer probe was cleaned in between uses to prevent the potential for cross-contamination and failed to cover and date food stored in the walk-in refrigerator. This	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice, 1) On 8.13.2023 at the time of discovery the Administrator ensured thermometer	9/11/23

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F 812	Continued From page 44 practice had the potential to affect food served to residents. Findings included: During an initial observation of the kitchen on 8/13/2023 at 10:00 am the walk-in refrigerator had a tray of serving bowls with 20 peaches and cream desserts that were not covered and did not have a date on them. The Cook stated the staff had put them out in the walk-in refrigerator yesterday and should have covered and dated the desserts. On 8/13/2023 at 11:34 am an observation was conducted of the lunch meal tray line. During the observation the Cook used a cloth hand towel, that had dark brown stains, to wipe the thermometer after checking each of the foods in the steam table for temperature. During an interview with the Cook on 8/13/2023 at 2:31 pm she stated she had worked at the facility for 1.5 years. The Cook also stated she had not used sanitizing wipes when she checked the temperatures of the different foods in the steam table on the tray line because there were not any sanitizing wipes available. She stated she thought using a clean towel would be okay. The Dietary Manager was interviewed on 8/15/2023 and he stated the Cook should have used sanitizing wipes that are in a drawer in the kitchen when she cleaned the thermometer, and the staff should have covered and dated the 20 desserts left in the walk-in refrigerator. He stated sometimes staff are slack on the weekends and he had done an in-service with the Cook and the rest of the kitchen staff as soon as he was aware	F 812	probe was cleaned and food was covered and dated appropriately that was stored in the walk-in refrigerator. Items that were identified as being not covered and not dated were discarded. No residents were affected by deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) This had the potential to affect food served to all residents. No other concerns were identified during subsequent observations. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, 3) The Dietary Manager will educate all dietary staff on the policy for proper cleaning of thermometers as well as storage and labeling for food by 9.06.2023. This education will be included in onboarding new dietary staff hired after 9.06.2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed 4) Dietary Manager will utilize a Quality Assurance monitoring tool to ensure thermometers are cleaned in between use and food stored in walk in refrigerator are covered and dated beginning on 9.07.2023. This monitoring will be completed 5 times per week for 4 weeks and then 3 times per week for 4 weeks	

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F 812	Continued From page 45 of the Cook using a hand towel to wipe the thermometer and staff leaving the 20 desserts uncovered and undated in the walk-in refrigerator. On 8/16/2023 at 4:30 pm the Administrator was interviewed and stated the Cook was not the full-time cook but had worked in food service for a long time and should have known better than to use a hand towel to wipe the thermometer when she checked the food temperatures, and the dietary staff should not have left the tray of 20 peaches and cream desserts with no cover over them and undated.	F 812	and then weekly for 4 weeks. Continued compliance will be monitored through the facilities Quality Assurance and Process Improvement Program for 3 months. Date of compliance will be 9.11.2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		9/11/23

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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 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.

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F 867	Continued From page 47 §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. §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	F 867		

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F 867	Continued From page 48 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 record review and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions the committee put into place in February 2022. This was for 1 re-cited deficiency which was originally cited on 2/11/2022 for drug storage (F761), on 4/5/2022 during the follow-up survey (F761), and on the current recertification/complaint survey on 8/21/2023 (F761). The continued failure of the facility during the three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: F761: Based on record reviews, observations, and staff interviews, the facility failed to store narcotic pain medications in a locked compartment in 1 of 1 medication rooms. During the recertification survey conducted 2/11/2022 the facility failed to: 1) Date opened (in use) injectable medications to allow for the	F 867	The facility will continue to ensure that the quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. The facility will continue to store narcotic pain medications in a locked compartment. The facility will continue to store and label drugs and biologicals according to facility policy. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice, 1) A facility reported investigation was completed on 2.21.23 related to 5 oxycodone/acetaminophen tablets that were missing from the medication room. No residents were affected by the missing medications. Address how the facility will identify other residents having the potential to be affected by the same deficient practice, 2) No further incidents of missing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 08/21/2023

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F 867	Continued From page 49 determination of a shortened expiration date in accordance with the manufacturer's instructions in 1 of 2 medication carts observed (100/300 Hall Med Cart); and 2) Store medications in accordance with the manufacturer's storage instructions in 1 of 2 medication carts observed (200 Hall Med Cart). During the follow up survey on 4/5/2022, the facility failed to discard an expired medication and label a multidose medication when opened for 1 of 3 medication carts (400 hall). An interview was conducted with the Administrator on 8/18/2023 at 11:02 AM by phone. The Administrator explained that QAPI committee met monthly with the department leaders, including the Director of Nursing, the Assistant Director of Nursing, the Unit Manager, and a floor nurse participating. The Administrator explained that the facility physician and the pharmacist would participate in quarterly QAPI meetings. The Administrator reported that the monthly QAPI committee discussed performance plans that were in place, modified action plans, and determined if there was a need to continue monitoring. The Administrator reported F761 from the 2022 survey was because insulin syringes had not been dated with the open date and because there were loose pills in medication carts. The Administrator reported that when the narcotic medications were discovered to be missing, a plan of correction, audits, monitoring, and QAPI committee discussions were initiated, and no further incidents of missing narcotic medications had occurred.	F 867	narcotic medications have occurred. No current residents have the potential to be affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur, 3) All licensed nurses were in-serviced by the DON on controlled narcotic substances as of 2.21.23. All licensed nurses were in-serviced by the pharmacy consultant on controlled medication guidance as of 2.28.23. The facility's quality assurance committee was in-serviced by the Regional Clinical Consultant on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns. Education included determining the root cause of the identified concern, identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised. This education was completed as of 8.22.23. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. 4) A QA monitoring tool was utilized to ensure that all drugs and biologicals were labeled and stored according to facility policy by the DON/designee beginning on 2.14.23. The DON/designee randomly observed medication labeling and storage a minimum of weekly concluding the week of 5.22.23. Variances were corrected at	

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F 867	Continued From page 50	F 867		

the time of observation and additional education provided when indicated.

Observation results were reported to the Administrator weekly from 2.14.23 through 5.22.23 and concerns were reported to the Quality Assurance Committee during monthly meetings.

A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator. The Regional Clinical Coordinator will attend the facility quality assurance meeting monthly x 3 months beginning in September to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated.

Continued compliance will be monitored through the facility's Quality Assurance Program.

Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.

The Regional Quality Assurance Nurse/Regional Operator will review the facility's quality assurance action plans monthly for the next 3 months then randomly thereafter to ensure continued compliance.