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	345156	A. BUILDING ______ B. WING ______	C 08/25/2023

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HARMONY HALL NURSING AND REHABILITATION CENTER	**312 WARREN AVENUE KINSTON, NC 28502**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation servey was conducted on 08/21/23 through 08/25/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# WOUN11.	E 000		
F 000	INITIAL COMMENTS A recertfication and complaint investigation was conducted on 08/21/23 through 08/25/23. Event ID# WOUN11. The following intakes were investigated: NC00196241, NC00206058, NC 00201799, NC00196799, NC00206264 and NC0198686. 3 of the 9 complaint allegations resulted in deficiency. The Statement of Deficiencies was amended on 9/15/23 at tags F584 and F641.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		9/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure advanced directive information matched throughout the medical record for 1 of 1 resident (Resident #25) reviewed for advanced directives. Findings included: Resident #25 was admitted to the facility on 10/28/19 with a diagnosis of Alzheimer's Disease. A review of Resident #25's electronic medical	F 578	Harmony Hall Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Harmony Hall Nursing and Rehabilitation	

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record revealed an active physician's order dated 10/29/19 for "CPR (Cardiopulmonary Resuscitation) Full Code".

A review of Resident #25's hard chart revealed a yellow "DNR (Do Not Resuscitate) form signed Resident #25's attending physician on 5/31/22. There was a box checked "no expiration".

A review of her quarterly Minimum Data Set (MDS) assessment dated 5/16/23 revealed Resident #25 was severely cognitively impaired.

On 8/23/23 at 10:18 AM an interview with the Director of Nursing (DON) indicated Resident #25's code status should be the same in her electronic record and her hard chart. She stated because Resident #25's code status was Full Code in the electronic record and DNR in her hard chart this could be confusing to nurses if Resident #25 needed CPR. She went on to say she would need to clarify Resident #25's wishes.

On 8/23/23 at 10:32 AM an interview with the Social Worker (SW) indicated Resident #25's wishes were that her code status be DNR. She stated she spoke with Resident #25's RP who expressed these wishes in May of 2022 and this had not changed. She went on to say Resident #25's code status should have been DNR beginning on 5/31/22 in both the electronic record and in her hard chart. The SW stated after a resident's DNR form was signed by their attending physician, she would place the form on the hard chart and enter the order into the resident's electronic record to be signed off by a nurse. She went on to say she was not sure why this had not happened with Resident #25.

F 578

Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Harmony Hall Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive

On 8/23/23, the social worker and Assistant Director of Nursing reviewed and updated resident #25 desire for advance directive and code status. The resident care plan was updated to reflect desired advance directive and code status and the golden rod advance directive form was placed in the resident chart.

On 8/23/23, the administrator initiated an audit of all resident orders for advance directive/code status. This audit is to ensure the Social Worker and/or nurse reviewed with the resident and/or resident representative the desired advance directive/code status, the physician was notified of desired advance directive/code status, an order placed in the electronic record, the care plan updated to reflect resident desired advance directive/code status and a golden rod advance directive form was placed in the resident chart for any resident identified as requesting Do

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F 578	Continued From page 3 On 8/25/23 at 2:31 PM an interview with the Administrator indicated the SW would have been responsible for entering Resident #25's DNR order into her electronic record.	F 578	Not Resuscitate. The Social Worker and/or nurse will address all concerns identified during the audit to include notification of the physician of desired advance directive/code status and updating electronic record when indicated. The audit will be completed by 9/25/23. On 8/23/23, the Administrator completed an in-service with the Social Worker, Admission Director, and Director of Nursing regarding Advance Directives with emphasis on ensuring the nurse and social worker reviews advance directives with the resident and/or resident representative upon admission, notify the physician of desired advance directive/code status, obtaining an order for code status and updating the electronic record/care plan. All newly hired social workers, admission director and/or Director of Nursing will be in-service during orientation regarding Advance Directives. On 8/29/23, the Administrator and Staff Facilitator initiated an in-service with all nurses regarding Advance Directives with emphasis on reviewing advance directives with the resident and/or resident representative upon admission, notification of the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic record/care plan, and ensuring a golden rod advance directive form in placed in the resident chart when indicated. In-service will be completed by 9/25/23. After 9/25/23 any nurse who has	

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F 578	Continued From page 4	F 578	not received the in-service will be in-service upon the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Advance Directives. The Medical Records Director, Minimum Data Set Nurse, and/or Assistant Director of Nursing will review all admissions/readmissions during Interdisciplinary Team Meeting (IDT) 5 times a week x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to ensure that the Social Worker, Admission Director and/or nurse reviewed advance directive/code status with the resident and/or resident representative upon admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and that the care plan was updated to reflect resident desired advance directive/code status. The Medical Records Director, Minimum Data Set Nurse, and/or Assistant Director of Nursing will address all concerns identified during the audit to include reviewing resident /resident representative preference for advance directive, obtaining order when indicated and updating resident chart for desired advance directive status. The Director of Nursing will review the Advance Directive Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the	

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F 578	Continued From page 5	F 578	Advance Directive Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		9/25/23

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§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, and staff interviews the facility failed to maintain resident rooms in good repair as evidenced by damaged drywall which included visible holes in the walls, scratched walls, and peeling paint which was observed in 12 of 25 resident rooms (Rooms 2203, 2212, 2215, 2218, 2221, 2302, 2315, 3412, 3416, 3418, 3503, 3516) reviewed for the provision of a safe, clean, homelike environment.

Findings included.

During the initial tour of the facility on 08/21/23 at 11:30 AM observations of resident rooms revealed multiple rooms with holes in the drywall, large scratches in the drywall around the residents beds, and paint peeling off the walls. The following was observed:

a. Room 2203 revealed multiple long scratches on the walls throughout the room.

b. Room 2212 revealed damaged drywall at the

F 584

F584 Safe/Clean/Comfortable/Homelike Environment

On 9/12/23, a work order was entered into TELs for repairs in rooms 2203, 2212, 2215, 2218, 2221, 2302, 2315, 3412, 3416, 3418, 3503 and 3516 to include repair of holes in the walls, scratched walls, peeling paint, or painting of previously repaired drywall. The work orders will be completed by 9/25/23.

On 9/13/23, the Admissions Director and Medical Records Director initiated an audit of all resident rooms. This audit is to identify any room that needs repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting to maintain a safe and homelike environment. The Administrator and Maintenance Director will address all concerns identified during the audit to include but not limited to

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side of the residents bed, with paint peeling off the walls.

c. Room 2215 revealed damaged drywall and peeling paint on walls.

d. Room 2218 revealed areas of drywall spackling compound on the walls that was dry and not painted, along with scratches in the drywall at the side of the residents bed.

e. Room 2221 revealed areas of drywall spackling compound that was dry and not painted, and scratches in the drywall at the side of the residents bed.

f. Room 2302 revealed scratched drywall at the head of the beds for beds A, B, and C.

g. Room 2315 revealed scratched drywall in room, with paint peeling off of the wall and air unit.

h. Room 3412 revealed drywall spackling compound at the head of the residents bed that was dry and not painted over.

i. Room 3416 revealed paint peeling off the walls in residents room at the head of the bed and the side of residents bed.

j. Room 3418 revealed damaged drywall with hole in the wall at the head of the residents bed, scratched wall at the head of the bed. Part of the towel rack was missing from the wall which was visible in the residents room.

k. Room 3503 revealed damaged drywall at the head of the residents bed.

F 584

repairing damaged walls and/or painting when indicated. The maintenance staff will review with the Administrator a timeline for completing identified concerns. Audit will be completed by 9/25/23.

On 9/12/2023, the Administrator completed an in-service with the Maintenance Director regarding Maintaining a Homelike Environment with emphasis on timely repair of facility and resident rooms to maintain a safe and homelike environment. The in-service also included notification of the Administrator for any concerns that cannot be addressed timely for additional recommendations/interventions.

On 8/29/23, the Staff Facilitator initiated an in-service with all nurses regarding Safe and Homelike Environment/Electronic Work Orders. Emphasis is the process for prompt reporting of any area in the facility in need of repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting in resident rooms to maintain a safe and homelike environment. In-service will be completed by 9/25/23. After 9/25/23, any staff who has not received the training will complete the in-service on the next scheduled work shift. All newly hired nurse, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical

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l. Room 3516 bed B revealed multiple scratched areas in the drywall around residents bed.

During an interview on 08/25/23 at 12:00 PM the Maintenance Director stated he had worked at the facility for two years. He stated the building was over 100 years old, with 2 levels and a basement and there were many areas around the building that needed work. He stated that he had repaired some of the holes in the drywall in many of the resident rooms since he began working at the facility. He stated it seemed as though once the wall was repaired, over time the holes or scratches would reappear. He stated a lot of the damaged drywall around the resident beds in multiple rooms was due to the beds pushing against or hitting the wall causing damage to the walls. He stated it was on ongoing effort to try to keep all of the walls maintained and in good repair. He stated he relied on staff as well to place a work order when things needed immediate attention. He stated he would get the walls repaired as soon as possible.

During an interview on 08/25/23 at 5:00 PM the Administrator stated she was aware of areas in the building that needed to be repaired. She stated the building was over 100 years old and needed work. She stated there was a plan to remodel and she hoped that would occur soon due to the many areas that needed to be upgraded and repaired. She stated the Maintenance Director was responsible for keeping the walls in good repair but realized it was an ongoing effort to keep the building properly maintained due to the age of the building. She stated she would ensure that the walls in the residents rooms get repaired

F 584

records director will be in-serviced during orientation regarding Safe and Homelike Environment.

The Admission Director and Medical Records Director will complete facility rounds to include all resident rooms weekly x 4 weeks then monthly x 1 month. This audit is to identify any area in the facility in need of repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting to maintain a safe and homelike environment. The Admission Director and Medical Records Director will complete a work order in TELs for all identified areas of concern and notify the Maintenance Director. The Maintenance Director will address all work orders submitted for concerns identified to include but not limited to repairing, painting damaged drywall when indicated. The Administrator will review the environmental rounds audit weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed.

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The Administrator will present the findings of the environmental rounds audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the environmental rounds audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring

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F 584	Continued From page 9 immediately	F 584		
F 602 SS=E	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 observations, record review, staff, Regional Pharmacy Services Manager, and Physician interviews the facility failed to protect a resident's right to be free from misappropriation of a resident's controlled hypnotic medication (Ambien) which was prescribed by the physician for insomnia. This resulted in 78 missing doses of Ambien for 2 of 2 residents (Resident #84, Resident #6) reviewed for misappropriation of medications. Findings included. 1a.) Resident #84 was admitted to the facility on 03/06/23 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Insomnia. A physicians order dated 03/06/23 for Resident #84 revealed an order for Ambien 10 milligram (mg) tablets. Administer one tablet by mouth at bedtime for Insomnia. The Minimum Data Set (MDS) admission	F 602	Past noncompliance: no plan of correction required.	

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assessment dated 03/13/23 revealed Resident #84 was cognitively intact. She required supervision with bed mobility, transfers, and activities of daily living (ADLs). She received scheduled hypnotics on 4 of 7 days during the assessment period.

A care plan dated 03/15/23 revealed Resident #84 received psychotropic and hypnotic medications. The interventions included in part; to administer medications per the physicians order.

Review of Resident #84's March 2023 Medication Administration Record (MAR) revealed multiple dates from 03/10/23 through 03/30/23, that Ambien 10 milligram (mg) tablets were documented on the MAR as not available for administration.

Review of Resident #84's April 2023 Medication Administration Record (MAR) revealed on 04/19/23 through 04/23/23, that Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of the Controlled Substance Count Record for Resident #84 for March 2023 and April 2023 revealed the entries made by staff were not legible and it could not be determined if the doses were signed out on the declining count record.

Review of the nursing progress notes dated 03/10/23 through 04/23/23 revealed no documentation as to why the Ambien 10 mg tablets were not available and were not administered to Resident #84. .

During an interview on 08/23/23 03:03 PM Resident #84 was observed lying in bed in her

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room. She was alert and oriented. She stated she needed the Ambien each night for sleep and stated she went for a period of time a few months ago when the medication was not available, but she could not recall a specific date or time. She stated she was only told the medication was not available from the pharmacy.

b.) Resident #6 was admitted to the facility on 11/10/22 with diagnoses including Heart Failure, Diabetes, and Insomnia.

A care plan dated 11/21/22 revealed Resident #6 received psychotropic and hypnotic medications. The interventions included in part; to administer medications per the physicians order.

A physicians order for Resident #6 dated 12/05/22 revealed Zolpidem Tartrate (Ambien) Oral Tablet 10 mgs. Give 10 mgs by mouth at bedtime for insomnia.

Review of Resident #6's March 2023 Medication Administration Record (MAR) revealed multiple dates from 03/03/23 through 03/16/23, that Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of Resident #6's April 2023 Medication Administration Record (MAR) revealed on 4/1, 4/2, 4/19, 4/20, and 4/21, that Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of the Controlled Substance Count Record for Resident #6 for March 2023 and April 2023 revealed the entries made by staff were not legible and it could not be determined if the dose was signed out on the declining count record.

F 602

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Review of the nursing progress notes dated 03/03/23 through 04/21/23 revealed no documentation as to why the Ambien 10 mg tablets were not available and were not administered to Resident #6.

The Minimum Data Set (MDS) quarterly assessment dated 06/26/23 revealed Resident #6 was cognitively intact. She required extensive one-to-two-person assistance with bed mobility, transfers, and activities of daily living (ADLs). She received hypnotics during the assessment period.

During an interview on 08/23/23 at 3:00 PM Resident #6 was observed lying in bed in her room. She was alert and oriented. She stated there was a period of time a few months ago when she was not receiving her nightly dose of Ambien. She stated she was only told the medication was not available from pharmacy.

Review of the facility investigation initiated on 04/21/23 revealed: On 04/21/23 the Nursing Supervisor notified the Director of Nursing (DON) and the Administrator of concerns related to the residents Ambien. Upon investigation the facility found a total of 50 missing Ambien 10 mg tablets for Resident #84 and a total of 28 missing Ambien tablets for Resident #6. The facility initiated an investigation to include review of pharmacy dispensing records for both residents. No Ambien medication was returned to the Pharmacy for either Resident. Identified residents were assessed with no difficulty sleeping. Reports were made to Adult Protective Services, the Police, the State Agency, and the Drug Enforcement Agency (DEA). No other residents received Ambien. Audits were conducted of the

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F 602	Continued From page 13 narcotic count sheets, packing slips, and return drug forms with no additional concerns related to narcotics. Assessments were completed for residents with difficulty sleeping, and new or worsening pain, with no negative findings. Audits were completed of the medication carts to ensure narcotic medications were present and available to administer per the physician orders. In-service training was conducted with all staff regarding misappropriation of resident property to include but not limited to medications. Witness statements were obtained. The facility investigation concluded; following staff witness statements, a review of narcotic records and pharmacy dispensing records it was substantiated that a total of 78 tablets of Ambien 10 mg tablets were unaccounted for. The facility could not determine the date that the medications became unaccounted for or how the medications became missing. The facility-initiated audits, in-services, and ongoing monitoring of the narcotic process. The allegation was substantiated due to the Ambien medication was missing. During an interview on 08/24/23 at 07:21 AM the Administrator stated that on 04/21/23 the Nursing Supervisor was responsible for the medication cart that contained Resident #84 and Resident #6's medications due to a staff member not showing up for work that morning. She stated the Nursing Supervisor thought the narcotic count sheet didn't look right and she reported this to her. She stated they immediately started an investigation and determined the Ambien for Resident #84 and Resident #6 was missing. She stated a full investigation was completed. She contacted the pharmacy and obtained dispensing records and determined that no Ambien was	F 602		

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F 602	Continued From page 14 returned to the pharmacy for Resident #84 or Resident #6. She stated she interviewed multiple staff members to obtain witness statements all denied changing or altering the dates and time on the Controlled Substance Count Record (narcotic declining inventory sheet). She stated the staff that were interviewed stated they were not aware that the Ambien was missing. She stated she and the Nursing Supervisor were unaware until that time that Resident #84 or Resident #6 were not getting the nightly dose of Ambien. She stated they could only speculate which staff member it was that took Resident #84 and Resident #6's Ambien. She stated that staff member called out on 04/21/23 the day the discrepancy was discovered. The staff member never returned phone calls and never showed up for work after 04/21/23. She stated they had not had any incidents of misappropriation of medications since this incident. She stated the corrective action plan completion date was 04/28/23. During an interview on 08/24/23 at 11:42 AM the Nursing Supervisor stated on 04/21/23 a Medication Aide was assigned to Resident #84 and Resident #6's medication cart due to a staff member not showing up for work that morning. She indicated she could not recall which Medication Aide was on the cart that morning. She stated the medication aide on duty put the declining inventory sheet (Controlled Substance Count Record)in her box at the nurses station that morning. When she looked at the declining inventory sheet it was not legible and didn't look right and she immediately reported this to the Administrator. She stated she checked the medication cart at that time and there was no Ambien available on the cart for Resident #84 or Resident #6. She stated they conducted a full	F 602		

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F 602	Continued From page 15 investigation and determined the medication was missing because it had been dispensed from pharmacy and should have been on hand. She stated that was why Resident #84 and Resident #6 did not receive the nightly dose of Ambien on the dates specified. She stated no staff had reported to her during that time from 03/10/23 through 04/23/23 that the medication was not available and that was why they didn't catch the discrepancy sooner. She stated a full investigation was conducted which included resident assessments, audits, in-service training and monitoring. During a phone interview on 08/24/23 at 01:53 PM the Regional Pharmacy Services Manager stated the pharmacy was not aware of any issue with Resident #84's Ambien until they were notified by the facility on 04/21/23. He stated upon investigation their records showed that thirty Ambien 10 mg tablets were dispensed to the facility for Resident #84 on 03/13/23, and thirty tablets were dispensed to the facility on 03/19/23, and thirty tablets were dispensed to the facility on 04/10/23. He stated the facility should have had the medication on hand and available for Resident #84 on the specified dates. During a phone interview on 08/24/23 at 01:53 PM the Regional Pharmacy Services Manager stated the pharmacy was not aware of any issue with Resident #6's Ambien until they were notified by the facility on 04/21/23. He stated upon investigation their records showed that on 01/20/23 the pharmacy dispensed to the facility thirty tablets of Ambien 10 mgs. On 03/17/23 the pharmacy dispensed thirty tablets of Ambien 10 mgs. On 03/29/23 the pharmacy dispensed five tablets of Ambien 10 mgs, then on 04/03/23 the	F 602		

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pharmacy dispensed thirty Ambien 10 mg tablets. He stated the facility should have had the medication on hand and available for Resident #6 on the specified dates.

During a phone interview on 08/25/23 at 5:00 PM Physician #1 stated she did not recall the details of Resident #84's or Resident #6's missing Ambien. She stated the facility most likely made her aware of the issue regarding the Ambien but stated she knew they had resolved the concern.

The corrective action for the noncompliance dated 04/28/23 was as follows:

On 04/21/23 the Assistant Director of Nursing (ADON) and the Nursing Supervisor initiated a 100% audit of the Medication Administration Records (MARs) and Controlled Substance Count Sheets for the last 30 days of all residents who received Controlled Substances, to include Resident #84 and Resident #6. The audit was to ensure the nurse or medication aide signed out the narcotics on the residents Control Substance Count Sheet to include quantity, date given, time given, quantity given, given by or destroyed by, quantity destroyed, method destroyed, witnessed by if destroyed, quantity left, as necessary, at the time of pulling the Controlled Substance. The audit was to ensure staff signed the electronic MAR that the narcotic was administered, and that documentation was completed for all as needed medications, to include date, hour, medication, dosage, route, reason, nurse initials, results, and response. All areas of concern were addressed by the ADON.

On 04/21/23 a 100% audit of all pharmacy packing slips for controlled substances and

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pharmacy Return of Control Substance Forms were initiated by the ADON and Nursing Supervisor to ensure there were no discrepancies in the Controlled Substance Count Sheets and that pharmacy received all medications per the Controlled Substance Return Form.

On 04/21/23 a 100% audit of residents receiving Zolpidem (Ambien) were assessed by the Nursing Supervisor for difficulty sleeping and/or new or worsening pain with no identified areas of concern.

On 04/21/23 the Administrator made the Medical Director, Pharmacy Consultant and Director of Pharmacy Clinical Services aware of the possible drug diversion.

On 04/21/23 the Administrator sent a 24-hour report of diversion of resident drugs to the Health Care Personnel Registry.

On 04/21/23 the Police Department was notified of the possible drug diversion by the Administrator.

On 04/21/23 The DEA was contacted by the Administrator and made aware of possible drug diversion.

On 04/21/23 an in-service was initiated with all nurses and medication aides by the Staff Development Coordinator (SDC) and Nursing Supervisor regarding Controlled Substance Diversion to include what is drug diversion, signs of diversion, following the chain of custody, declining count sheets, delivery manifest, Controlled Substance Return Forms, narcotic counts between shifts, reporting discrepancies,

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F 602	Continued From page 18 and documentation of narcotic administration. In-services were to be completed by 04/27/23. After 04/27/23, any staff who had not received the in-service training would receive it prior to their next scheduled work shift. All newly hired nurses and medication aides would be in-serviced during orientation by the Staff Facilitator in regard to Controlled Substance Diversion to include what is drug diversion, signs of diversion, following the chain of custody, declining count sheets, delivery manifest, Controlled Substance Return Forms, narcotic counts between shifts, reporting discrepancies, and documentation of narcotic administration. On 04/21/23, 100% in-service training was initiated by the SDC and Nursing Supervisor with all staff regarding Misappropriation of Property. In-service to be completed by 04/27/23. After 04/27/23, any staff who had not received the in-service would receive it prior to their next scheduled work shift. All newly hired staff would be in-serviced during orientation by the Staff Facilitator regarding misappropriation. The ADON, Nursing Supervisors, MDS nurse and Staff Development Coordinator will audit narcotic count sheets, packing slips, and return of drug sheets verified by pharmacy utilizing the Narcotic Count sheet Audit Tool 5 times per week x 4 weeks to ensure 2 nursing staff have completed the narcotic count sheet for all narcotics at the beginning and end of each shift, and to ensure nurses have completed the medication count accurately to include looking at both the count sheet and the supply on hand by both nurses and the medication aides and that Narcotics were administered per physicians order with documentation on both the MAR and the	F 602		

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F 602	Continued From page 19 declining count sheet. The DON or ADON will address all concerns identified during the audits to include but not limited to education of the nurse. The DON will review all audits weekly x 4 weeks to ensure all concerns were addressed. The Director of Nursing will forward the results of the Narcotic Count sheet Audit Tool to the Quality Assurance (QA) Committee Meeting monthly x 1 month. The QA Committee will meet and review the Narcotic Return Audit Tool monthly x 1 month to identify any potential trends and determine the need for action and/or frequency of continued monitoring. Alleged Completion Date: 04/28/23 Validation of the corrective action was completed on 08/25/23. This included staff interviews regarding the incident, and in-service training that was received to ensure understanding and knowledge of the training provided. Observations were conducted of the medication carts; controlled substance counts were conducted with nursing staff of narcotics stored on the medication carts. Controlled Substance Count Records were reviewed. Audits were verified. A QA meeting was held on 06/30/23 where audit results were discussed. The facility's alleged completion date for the corrective action plan was validated as 04/28/23.	F 602		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		9/25/23

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F 641	Continued From page 20 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to accurately code Minimum Data Set (MDS) assessments to reflect Hospice Services (Resident #26), application of dressings and ointments to a wound (Resident #80), and dental status (Resident #25) for 3 of 26 residents whose MDS assessments were reviewed. Findings included: 1. Resident #26 was admitted to the facility on 04/28/23 with diagnoses that included Alzheimer ' s disease with late onset, adult failure to thrive and Hospice Care. Review of a Hospice progress note dated 07/11/23 documented the Hospice Care Plan had been reviewed. Monthly progress notes were on file and reviewed. A quarterly Minimum Data Set (MDS) Assessment dated 07/24/23 documented Resident #26 had moderately impaired cognition. She had a life expectancy of less than six months to live. She was not receiving Hospice Services. In an interview with the MDS Coordinator on 08/24/23 at 9:50 AM she stated Section O should have been coded to reflect Resident #26 was receiving Hospice Services. She noted Resident #26 had been admitted with Hospice Services and had no lapse in services since admission. She concluded it was a human error and she would file an assessment modification.	F 641	F641 Accuracy of Assessments On 8/24/23, the MDS Coordinator completed a modification of a quarterly assessment dated 7/24/23 for resident #26 to reflect accurate coding of hospice status. On 8/24/23, the MDS Coordinator completed a modification of a quarterly assessment dated 7/11/23 for resident #80 to reflect accurate coding of dressings/ointments/medications for wound care. On 8/24/23. the MDS Coordinator completed a modification of the annual assessment completed 12/12/22 for resident #25 to reflect accurate coding of dentation. On 9/13/23, the Administrator and nurse consultant initiated an audit of the most recent MDS assessment section O from for all residents receiving hospice to include Resident #26 to ensure all MDS□s assessments completed are coded accurately to include all residents that are receiving hospice services. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from DON. The audit will be completed by 9/25/23. On 9/13/23, the staff facilitator and nurse	

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In an interview with the Administrator on 08/24/23 at 12:08 PM she stated that the Hospice Nurse came weekly to assess Resident #26. She stated she expected the assessment to be coded to reflect Resident #26 had received Hospice care.

2) Resident #80 was admitted to the facility on 12/22/21 with diagnoses that included, in part: a pressure ulcer of the sacral region Stage 4.

Review of the July 2023 Treatment Administration Record revealed dressings and ointments/medications were applied to the resident's wound during the assessment look back period on 07/05/23, 07/07/23, and 07/10/23.

Review of a quarterly MDS assessment dated 07/11/23 documented Resident #80 had one Stage 4 pressure ulcer that was present on admission. She had pressure relieving devices to her chair and bed. She received pressure ulcer care. She had not received dressings or ointments/medications for the wound.

In an interview with the MDS Coordinator on 08/24/23 at 9:50 AM she stated Section M of the MDS assessment for Resident #80 should have been coded to reflect that the resident had received dressings and applications of ointments/medications to the wound during the assessment period. She noted it was a human error and stated she would file an assessment modification to correct the error.

In an interview with MDS Nurse #10 on 08/24/23 at 10:00 AM she stated she had completed the assessment for Resident #80 and had no excuse for not coding the assessment to reflect the

F 641

consultant initiated an audit of the most recent MDS assessment section L to ensure all residents are coded accurately for dentation to include Resident #25. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from DON. The audit will be completed by 9/25/23.

On 9/13/23, the Administrator and nurse consultant initiated an audit of the most recent MDS assessment section M to ensure all residents with wounds are coded accurately for wound care/treatment to include Resident #80. The MDS nurses will complete modifications during the audit for any identified area of concern with the oversite from DON. The audit will be completed by 9/25/23.

On 9/12/23, the clinical consultant completed an in-service with the Director of Nursing (DON) and all Minimum Data Set Nurses (MDS) regarding MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on ensuring assessments are coded accurately on the MDS assessment to include but not limited to residents that are receiving hospice services, residents on antipsychotic medication, wound treatment and/or resident dentation. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation.

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F 641	Continued From page 22 resident had received a dressing and ointments/medications to a wound during the assessment period. She commented that she simply made an entry error. In an interview with the Administrator on 08/24/23 at 12:08 PM she stated she expected the assessments to be completed accurately. 3. Resident #25 was admitted to the facility on 10/28/19 with a diagnosis that included Alzheimer's Disease. A review of her annual Minimum Data Set (MDS) assessment dated 12/12/22 revealed Resident #25 was severely cognitively impaired. It further revealed she had no obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) for dental was not triggered. A review of Resident #25's current comprehensive care plan last revised on 8/7/23 did not reveal a focus area for dental. On 8/22/23 at 9:06 AM an observation of Resident #25 revealed she had multiple black teeth broken to the gumline. On 8/24/23 at 11:32 AM an interview with MDS Nurse #1 indicated she completed the dental section of Resident #25's annual MDS dated 12/12/22. She stated she normally reviewed any dental notes and observed the resident's mouth if the resident would cooperate. She stated Resident #25 did have obvious cavity and broken natural teeth. She stated she made an error when she coded this section of Resident #25's annual MDS. MDS Nurse #1 stated fixing this would trigger an additional CAA and require a significant	F 641	The Staff Facilitator will audit of 10% of completed MDS assessments, to include assessments for resident # 80, resident #26 and resident #25 utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include residents that are receiving hospice services, residents with wound treatment/dressings and resident dentation. All identified areas of concern will be addressed immediately by the DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 641	Continued From page 23 correction. On 8/25/23 at 2:31 PM an interview with the Administrator indicated resident's MDS assessments should accurately reflect their condition.	F 641		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to provide incontinence care safely to a dependent resident for 1 of 1 residents reviewed for falls. Resident #307 fell out of bed during incontinence care provided by Nursing Assistant (NA) #1 resulting in an upper lip laceration which required to 7 sutures, a laceration to the left side of the head that required 12 staples and a small laceration to the 2nd digit on the left foot. Findings included: Resident #307 was admitted to the facility on 12/3/18 with medical diagnosis which included in part: stroke with hemiparesis, vascular dementia, contractures of left wrist and hand and right hand, aphasia, and epilepsy.	F 689	Past noncompliance: no plan of correction required.	

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Review of Resident #307's 11/23/22 annual Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment with no behaviors. Resident #307 required total assistance of 2 people with bed mobility and toileting. Resident #307 had impaired range of motion on both sides of the upper extremities and impairment on 1 side of her lower extremities. Resident #307's height was 61 inches, and her weight was 172 pounds. Resident #307 did not receive an anticoagulant during the lookback period.

Resident #307's care plan updated on 12/1/22 revealed a plan of care for activities of daily living (ADLs) personal care. The care plan interventions indicated Resident #307 was dependent for bathing and personal hygiene and required 2-person assist with bed mobility.

Resident #307's undated care guide indicated 2-person assist was required with bed mobility.

Review of Resident #307's electronic medical record revealed a nursing health status note written by Nurse # 1 on 1/22/23 at 11:21 PM. The note read in part "called to room by aide, found resident on the floor face down with a large amount of blood." The note further indicated Emergency Medical Service (EMS) was alerted and Resident #307 was transported to the hospital.

Review of an incident report completed by Nurse #1 on 1/22/23 at 11:30 PM revealed she was called to the room by NA #1. The note stated that Resident #307 was observed lying face down with blood noted around the head area. The note

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indicated that Nurse #1 could not tell where the blood was coming from. Emergency Medical Service (EMS) was called, and Resident #307 was transferred to the hospital.

Review of a 1/23/23 statement completed by NA #1 indicated she was assigned to Resident #307 on the evening shift on 1/22/23. The statement indicated at approximately 7:15 -7:30 PM NA #1 provided incontinence care to Resident #307. NA #1 indicated Resident #307 was positioned in bed. NA #1 indicated following incontinence care she pushed the resident onto the left side with her left hand. NA #1 then placed her right hand on resident's right side and turned to reach for a clean brief when Resident #307 rolled off the bed onto the floor. NA #1 stated Resident #307 hit the nightstand with her head and landed face down on the floor. NA #1 immediately notified Nurse #1 that Resident #307 was on the floor.

Attempts were made 3 times by phone and text message to contact NA # 1 on 8/23/23 and 8/24/23 without success.

An interview was conducted on 8/22/23 at 3:55 PM with Nurse # 1. Nurse # 1 revealed she was assigned to Resident #307 on 1/22/23. Nurse # 1 stated NA #1 turned Resident #307 away from her while providing incontinence care. Nurse # 1stated Resident #307 was too close to the edge of the bed and rolled off.

An interview was conducted on 8/23/23 at 1:25 PM with Nurse #3. Nurse #3 revealed she was working the night of 1/22/23 and responded to the room following Resident #307's fall. Nurse #3 observed Resident #307 lying face down on the floor by the bed and there was a large amount of

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blood.

Review of the hospital records revealed an emergency department provider note dated 1/22/23 which indicated Resident #307 presented to the emergency department with profuse bleeding from a scalp and a lip laceration after a fall while staff were attending to her. Physical exam indicated Resident #307 had a 3.5 centimeter left posterior scalp laceration and a 2-centimeter upper lip laceration. Resident #307 received 7 sutures to the upper lip and 12 staples to the scalp. The note further indicated Resident #307 underwent a CT scan which revealed no cranial hemorrhage. Resident #307 returned to the facility on 1/23/23.

An interview was conducted on 8/23/23 04:35 PM with the Assistant Director of Nursing (ADON). The ADON revealed she completed the investigation of Resident #307's 1/22/23 fall. The ADON stated that as part of the investigation, NA #1 demonstrated what happened when Resident #307 fell. The ADON stated NA #1 demonstrated she turned Resident #307 away from her while providing incontinence care. The root cause analysis of the fall was improper turning and repositioning. The ADON stated if NA #1 had turned the resident toward her during care the fall could have been prevented. The ADON further stated the care guide indicated Resident #307 required 2-person assistance with mobility. The ADON stated NA # 1was trained on how to provide incontinence care to a dependent resident when she was hired. The ADON stated all nurses and NAs were retrained after this incident on how to properly turn and reposition a resident and were required to complete return demonstrations. The ADON stated NA #1 was

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retrained and was not allowed to provide patient care until she completed the retraining and demonstrated that she knew how to safely provide care.

An interview was conducted with the Administrator on 8/24/23 at 7:15 AM. The Administrator revealed that a full investigation of the incident was completed, and a Plan of Correction was completed after the fall. The Administrator stated that the Plan of Correction consisted of audits and in service education with all nurses, NAs and Medication Aides regarding turning and repositioning.

Interview on 8/24/23 at 2:35 PM with the Physician revealed due to Resident #307's dependent status with history of stroke with hemiparesis, the NA should not have turned the resident away from her during care.

An interview was conducted on 8/24/23 at 4:00 with the Nursing Supervisor. The Nursing Supervisor revealed Resident #307 required total care, was nonverbal and required 2 person assist with mobility. The Nursing Supervisor stated that all nurses and NAs received in service training regarding safe handling following Resident #307's fall on 1/22/23.

An interview on 8/25/23 at 9:56 AM with the Director of Nursing (DON) revealed safe handling was the root cause of the incident with Resident #307 on1/22/23. Root cause analysis was investigated and training and in services were provided to all nurses and NAs following the incident.

The facility provided the following Corrective

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F 689	Continued From page 28 Action Plan with a completion date of 2/15/23: 1. On 1/22/23 approximately 7:15-7:30 PM Resident #307 was in bed receiving incontinence care by one Nursing Assistant (NA). Resident #307 was positioned with the head of bed elevated with her hips in the center of the bed and legs slightly to the left. NA lowered the head of the bed, raised the bed to the height of about 2.5 to 3 feet and began to provide incontinence care. Upon interviewing the NA, she stated following incontinence care, she pushed the resident onto the left side with her left hand while raising resident's right leg up and over the left leg resulting in the resident being positioned along the edge of the bed on the left side. The NA stated when reaching for a brief, the resident continued to take a forward motion to the left side of the bed. The NA was unable to stop the forward motion of the resident and she rolled off the bed onto the floor. The assigned nurse on duty and another nurse assessed the resident, observed a large amount of blood on the floor around resident's head and determined the resident would be sent to the emergency room for evaluation. Emergency Medical Services (EMS) arrived at the facility and transported resident to the hospital for evaluation. Resident underwent a CT scan of the head which revealed no cranial hemorrhage. Resident received 7 sutures to the upper lip laceration and 12 staples to the scalp laceration. Resident remained in the emergency room overnight and returned to the facility on 1/23/23. 2. The Nurse Aide involved was not permitted to provide resident care pending investigation and education regarding safe handling and turning and repositioning. The Nursing Assistant was	F 689		

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F 689	Continued From page 29 also asked to do a return demonstration of the incident. The Assistant Director of Nursing met with the Nursing Assistant on 1/23/23, written statement was received, and education was provided. The Nursing Assistant provided demonstration of the incident and following education completed a demonstration of proper handling and turning and repositioning. 3. Reeducation to the nursing staff to include Nursing Assistants, nurses and Medication Aides was initiated on 1/23/23 by the Assistant Director of Nursing (ADON) and nursing supervisor. Education included proper turning and positioning procedure, safe handling and following the resident care guide. All nursing staff will receive education prior to next scheduled shift. Education is congoing for new hired staff. The Director of Nursing (DON) initiated an in service with all nurses, Nursing Assistants and Medication Aides regarding positioning in bed with emphasis on the providing care in bed to the dependent resident, safe handling and utilizing the care guide. " 100% audit of all resident positioning needs in bed. " 100% audit utilizing a questionnaire with all cognitively intact residents regarding any concerns related to turning and positioning during care. " 100% audit of all falls in the prior 30 days " 100% audit of resident care plans and care guides to ensure correct information in place and updated as needed. " Staff Development Coordinator and/or Nursing Supervisor will complete 5 random weekly observations of staff providing bed mobility and proper positioning during care for 4	F 689		

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F 689	Continued From page 30 weeks. 4. Results of the 5 random weekly observations will be discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for one month to determine trends or issues that may require further interventions or monitoring to sustain substantial compliance. 5. Allegation of Compliance Date: 2/15/23. The Corrective Action Plan was validated on 8/24/23 and concluded the facility implemented an acceptable corrective action plan on 2/15/23. Interviews with nursing staff revealed the facility had provided education and training on proper turning and repositioning and safe handling. Staff interviewed verbalized they received in service training including return demonstration of competency prior to starting their next shift. Review of the facility audit tools revealed 100% audit of resident positioning needs in bed was completed. Audit records further revealed questionnaires were completed with all cognitively intact residents regarding turning and positioning during care. 100 % of the falls in the prior 30 days were reviewed. No concerns were identified as a result of the audits. Review of the monitoring tools of safe handling and turning and repositioning that began on 1/24/23 were completed weekly as outlined in the corrective action plan with no concerns identified.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		9/25/23

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F 692	Continued From page 31 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to obtain daily weights as ordered by the physician and failed to accurately document a weight or obtain a reweigh for 1 of 1 resident (Resident #4) reviewed for nutrition. Findings included. Resident #4 was admitted to the facility on 04/12/22 with diagnoses including Congestive Heart Failure (CHF), and End Stage Renal Disease with Hemodialysis. A care plan dated 05/20/23 revealed Resident #4 had the potential for fluid volume excess related to congestive heart failure. Interventions included	F 692	F692 Nutrition/Hydration Status Maintenance On 8/26/23, the order for daily weights for resident # 4 was clarified with the physician with a new order to discontinue daily weight monitoring. Weight has been stable since 8/24/23. On 9/13/23, the Dietary Manager initiated an audit of all orders for daily weight monitoring to ensure weights were obtained per physician and the physician notified when weights exceeded parameters. The Assistant Director of Nursing will address all concerns identified during the audit to include	

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in part; to maintain fluid restrictions and obtain weights as ordered.

The Minimum Data Set (MDS) quarterly assessment dated 06/13/23 for Resident #4 revealed she was cognitively intact. She required extensive assistance with activities of daily living (ADL's). She received a therapeutic diet and had no weight loss or gain at the time of the assessment. She was compliant with care and received hemodialysis.

A physicians order dated 08/10/23 for Resident #4 revealed to obtain daily weights and notify the physician if greater than a 5 lb. (pound) weight gain.

A review of Resident #4's weights on 08/24/23 revealed the following:

08/10/23 the recorded weight was 219.6 lbs.
07/12/23 the recorded weight was 175.3 lbs.
07/07/23 the recorded weight was 179.9 lbs.

Review of Resident 4's progress notes from 08/10/23 through 08/24/23 revealed no documentation that a daily weight was recorded.

During an interview on 08/24/23 at 4:00 PM Nurse Aide #2 stated she routinely provided care for Resident #4. She stated the nurse aides typically obtained and documented the resident weights. She indicated the nurse would let them know if daily weights were needed and stated she was not aware of Resident #4 needing daily weights.

During an interview on 08/24/23 at 12:07 PM Nurse #7 stated she routinely provided care for

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obtaining weight when indicated, notification of physician when weight exceeds parameters for further recommendations and/or education of the staff. The audit will be completed by 9/25/23.

On 9/13/23, the Assistant of Director of Nursing (ADON) initiated an audit of all consults from 8/11/23-9/11/23. This audit is to ensure the consultation report is review upon return to the facility for new orders/recommendations and that all orders/recommendations are transcribed to the electronic record and completed per physician orders to include but not limited to daily weight monitoring. The ADON and Nurse Supervisor will address all concerns identified during the audit to include updating the electronic record when indicated, notification of the physician for any order not completed as recommended and/or education of staff. The audit will be completed by 9/25/23.

On 8/29/23, the Staff Facilitator initiated an in-service with all nurses regarding Transcription of Orders/Consults with emphasis on checking consultation reports for new orders/recommendations, notification of the physician of new orders/recommendations, transcribing orders to the electronic record and notification of the physician for any order/recommendation that is unclear for clarification. The in-service will be completed by 9/25/23. After 9/25/23, any nurse who has not worked or received the in-service will complete it upon next

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Resident #4. She stated Resident #4 received a renal diet, was on fluid restrictions, and her weights were done monthly. She stated the nurses transcribed the orders that come in from the physician appointments. She indicated she was not aware of daily weights ordered on 08/10/23 for Resident #4 and stated she was not sure which nurse was working on 08/10/23 and missed the order. She stated it was an error. She stated the nurse aides obtained the monthly weights and the weight recorded on 08/10/23 of 219 lbs. could not be accurate and staff should have obtained a reweigh. She indicated upon review of Resident #4's electronic medical record a reweigh was not recorded.

During an interview on 08/24/23 at 1:44 PM the Nursing Supervisor stated Resident #4 was seen at Physician #2's office on 08/10/23 and returned with the physicians order for daily weights. She stated the process was for the physician orders to go to the nurse on the floor to transcribe, then the order is placed in her box. She stated she was not aware of the order on 08/10/23 for daily weights and to notify the physician if greater than a 5 lb. weight gain. She stated the weight recorded on 08/10/23 of 219 lbs. included the wheelchair weight and Resident #4 should have been reweighed at that time for accuracy. She stated a new weight was obtained this morning on 08/24/23 of 170.5 lbs. She stated the order was missed in error and would be corrected immediately.

During a phone interview on 08/25/23 at 3:15 PM Physician #2 stated Resident #4 had a diagnoses of congestive heart failure and typically CHF patients required tracking and monitoring of weights to identify fluid overload early which was

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scheduled work shift. All newly hired nurses will be in-service during orientation regarding Transcription of Orders/Consults.

The Director of Nursing, ADON, Nurse Supervisor, Staff Facilitator and Minimum Data Set (MDS) nurse will review 10% consultation reports 5 x a week x 4 weeks then monthly x 1 month using Consultation Audit Tool. This audit is to ensure consultation reports are reviewed and that all physician orders/recommendations are transcribed to the electronic record and completed per physician orders to include but not limited to daily weight monitoring. The Director of Nursing, ADON, Nurse Supervisor, Staff Facilitator and Minimum Data Set (MDS) nurse will address all concerns identified during the audit to include updating the electronic record when indicated, notification of the physician for any order not completed as recommended and/or re-training of staff. The Administrator will review the Consultation Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The ADON and Nurse Supervisor will review all residents with orders for daily weights weekly x 4 weeks then monthly x 1 month to ensure weights were obtained per physician and the physician notified when weights exceeded parameters. The ADON and Nurse Supervisor will address all concerns identified during the audit to include obtaining weight when indicated, notification of physician when weight

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F 692	Continued From page 34 why the order was written for daily weights. He stated now that Resident #4 was on hemodialysis the concern for fluid overload was less due to hemodialysis removing the excess fluid. He stated as long as Resident #4 received dialysis there would be no significant concerns with not getting daily weights done and stated she was compliant with dialysis. He stated he did expect that staff followed the physician orders and stated Resident #4 should get daily weights and weights should be recorded accurately. During an interview on 08/25/23 at 5:00 PM the Administrator stated Resident #4 should have received daily weights since 08/10/23. She stated staff should have entered the order into the electronic medical record at that time. She stated education would be provided to nursing staff regarding entering physician orders and obtaining and accurately documenting resident weights.	F 692	exceeds parameters for further recommendations and/or education of the staff. The Administrator will forward the results of the Consultation Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Consultation Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		9/25/23

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F 755	Continued From page 35 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, the resident, the Regional Pharmacy Services Manager and the Physician, the facility failed to acquire and administer temazepam, a controlled substance medication used for insomnia, for Resident #31 for a period of 4 days for 1 of 3 residents whose medications were reviewed. Findings included: Resident #31 was admitted to the facility on 1/25/21 with medical diagnoses which included in part: congestive heart failure, depression, and insomnia. Review of Resident #31's medical record revealed a physician order dated 6/14/23 for temazepam oral capsule 15 milligrams. Give 1 capsule by mouth at bedtime for insomnia.	F 755	F755 Pharmacy Services On 8/18/23, the pharmacy refilled resident #31 temazepam. Resident #31 has received temazepam per physician order without interruption since 8/19/23. On 9/13/23, the Nurse Supervisor, Assistant Director of Nursing (ADON) and Director of Nursing (DON) initiated an audit of all medication carts to ensure medications are available to be administered per physician order. The Nurse Supervisor, Assistant Director of Nursing (ADON) and Director of Nursing (DON) will address all concerns identified during the audit to include notification of the physician/pharmacy for refill orders when indicated and/or obtaining medications from back up pharmacy when indicated. The audit will be completed by 9/25/23.	

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F 755	Continued From page 36 Review of Resident #31's August 2023 medication administration record (MAR) revealed that on 8/15/23, 8/16/23, 8/17/23 and 8/18/23 the documentation for temazepam was charted as 10 which indicated that the medication was not administered due to not available. Interview with Resident #31 on 8/21/23 at 12:45 PM revealed she did not receive her sleep medication for several nights due to it was not available in the facility. Resident #31 stated she was upset the nights she did not receive the medication because she could not sleep and feared she was going to have withdrawals. Review of the Controlled Substance Count Record for Resident #31 revealed a count sheet dated 8/18/23 for temazepam 15 milligrams. The count sheet indicated 30 tablets sent by pharmacy on 8/18/23. Interview on 8/23/23/ at 1:00 PM with Nurse #1 revealed she was assigned to Resident #31 on the evening of 8/16/23. Nurse #1 indicated documentation of 10 on the MAR meant the medication temazepam was unavailable and she did not administer it. Nurse #1 stated that the medication temazepam was not in the medication cart on 8/16/23 and was not in the facility, so she did not administer it and documented 10 on the MAR. Nurse #1 revealed that she did not inform the physician that the medication was unavailable and did not attempt to obtain the medication. Interview with Nurse #3 on 8/23/23 at 1:18 PM revealed that if the supply of a medication was getting low, the nurse was to call the pharmacy, order the medication on the computer or fax the refill request to the pharmacy. Nurse #3 indicated	F 755	On 9/13/23, the Nurse Supervisor initiated an audit of all medications listed as not available to administer from 8/25/23/23 to 9/12/23. This audit is to ensure medications are available and administered per physician order. The Nurse Supervisor will address all concerns identified during the audit to include obtaining medications from pharmacy and/or notification of the physician for further recommendations when medication cannot be obtained. The audit will be completed by 9/25/23. On 8/29/23, the Staff Facilitator initiated an in-service with all nurses regarding Obtaining Medications with emphasis on ordering medications timely to ensure medication available to administer per physician order, obtaining medications from eKit or back up pharmacy and notification of the physician when medications cannot be obtained for further instructions and/or alternative medication. The in-service will be completed by 9/25/23. After 9/25/23, any nurse who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Obtaining Medications. The Assistant Director of Nursing (ADON), Staff Facilitator and/or Nurse Supervisor will review the Orders Listing Report for medications not available 5 times a week x 4 weeks then monthly x 1 month to ensure medications were	

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F 755	Continued From page 37 she thought temazepam was refilled without a new prescription, but she was not sure. Nurse #3 indicated the facility had an emergency kit that contained some medications, but it did not contain temazepam. Nurse #3 stated that if a medication was not available, she did not give it. Nurse #3 recalled that Resident #31 was out of the medication temazepam recently, but she did not know why or how that happened. Nurse #3 stated that documentation of 10 on the MAR indicated the medication was not administered due to it was not available. Interview on 8/23/23 at 4:14 PM with MDS Nurse #2 revealed she was assigned to Resident #31 in the evening on 8/18/23. MDS Nurse #2 stated she documented a 10 on Resident #31's MAR on the evening of 8/18/23 indicating the medication was not available and she did not give it. MDS Nurse #2 stated she did not know why the medication was not available, she had not attempted to obtain it and had not notified the physician. MDS Nurse #2 revealed medication aides worked the medication carts and they don't check when refills were needed. MDS Nurse #2 stated no one was assigned to audit the medication carts for refills. Interview on 8/24/23 at 5:20 AM with Nurse #3 indicated she was assigned to Resident #31 on 8/15/23 and 8/17/23. Nurse #3 revealed some medications required a prescription for refills. Nurse #3 stated all the nurses were supposed to send requests to the provider to obtain a prescription for refills. Nurse #3 further stated no one was assigned to check when the refills were needed or to send the requests to the physician to obtain prescriptions for refills of controlled substances. Nurse #3 stated she was assigned to	F 755	available and administered per physician orders. The Unit Managers, ADON and/or Nurse Supervisor will address all concerns identified during the audit to include obtaining medications when indicated, notification of the physician when medications cannot be obtained for further instructions with documentation in the electronic record and/or re-training of staff. The Director of Nursing (DON) will review the Orders Listing Report for medications not available weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Orders Listing Report for medications not available to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Orders Listing Report for medications not available report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 755	Continued From page 38 Resident #31 on 8/15/23 and 8/17/23, she charted 10 on the MAR for temazepam which indicated the medication was not available in the facility and she did not administer it. Nurse #3 stated she did not attempt to obtain the medication or notify the physician. An interview on 8/24/23 at 1:00 PM with the Regional Pharmacy Services Manager revealed that the physician can authorize up to 5 refills of the medication temazepam or the medication can be filled for a 6 months' supply. The Regional Pharmacy Services Manager stated that each time a supply of the medication was required, it would not necessarily require a new prescription from the physician, as long as they had not exceeded the 5 refills. The Regional Pharmacy Services Manager indicated that some residents experience insomnia and nervousness or restlessness from missing a dose of temazepam. During a follow up interview on 8/24/23 at 1:45 PM with the Regional Pharmacy Services Manager he revealed that the refill request for Resident #31 for temazepam was received from the facility on 8/18/23. The pharmacy received an electronic prescription on 8/18/23 for Resident #31 for temazepam 15 milligrams give one tablet at bedtime for sleep. After the electronic prescription was received, the pharmacy dispensed 30 tablets of temazepam for Resident #31. An interview was conducted on 8/24/23 at 2:45 PM with the Physician. The Physician revealed that the nurses at the facility contacted the physician's office to request refills of medications and she promptly completed the refill order. The physician stated she was not informed that	F 755		

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F 755	Continued From page 39 Resident #31 did not receive the ordered temazepam on 8/15, 8/16, 8/17 and 8/18/23 due to it was not available. The physician stated that it may not have affected Resident #31 to miss the scheduled doses of temazepam, but it should have been reported and the refill should have been requested before the resident ran out of medication. An interview was conducted on 8/24/23 at 3:49 PM with the Nursing Supervisor. The Nursing Supervisor revealed the nurses sometimes told her and she contacted the doctor's office to request a refill for a controlled substance. The Nursing Supervisor stated that on 8/18/23 she was told the refill was needed for Resident #31's temazepam and she requested the refill from the physician. The Nursing Supervisor stated there was no one assigned to check the medications on the medication cart to be sure the residents had their ordered medications. The Nursing Supervisor further stated that she was not informed until 8/18/23 that Resident #31 required a refill of her ordered temazepam. An interview was conducted on 8/25/23 at 10:14 AM with the Director of Nursing. The DON stated the physician was to be notified in a timely manner that a new prescription was needed for a refill of a controlled substance. The DON stated the physician should be notified when a medication was unavailable to determine if there was a substitute. The DON stated the Nursing Supervisor usually handled contacting the physician when refills were needed. DON further stated that a medication was not to be omitted due to not available.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On	F 756		

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F 756	Continued From page 40 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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F 756	Continued From page 41 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician, and Regional Pharmacy Services Manager interviews the facility failed to address drug irregularities noted by the Consultant Pharmacist on six consecutive monthly Medication Regimen Reviews for an antipsychotic medication prescribed by the physician for 1 of 5 residents (Resident #10) reviewed for unnecessary medications. Findings included: Resident #10 was admitted to the facility on 11/16/20 with medical diagnoses which included in part: dementia wiht behaviors and major depression with psychoses. Review of an 8/17/22 pharmacy recommendation note to Resident #10's physician indicated a recent DISCUS (Dyskinesia Identification System condensed User Scale-an exam used to identify involuntary movements of the tongue, lips, eyes, upper and lower limbs associated with psychotropic medication, showed worsening abnormal voluntary movements. The note read in part: "Please review the dose of risperidone at this time for potential discontinuation due to change in movements. "The physician signed the recommendation on 8/27/22 indicating agreement with the recommendation and indicated to decrease risperidone to 0.25 milligrams once per day. Resident #10's September Medication Administration Records (MAR) revealed resident received risperidone 0.5 mg. one time per day	F 756	Past noncompliance: no plan of correction required.	

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from 9/1/23 through 9/30/23.

Review of a 9/21/22 document titled Consultant Pharmacist's Medication Regimen Review read "the MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan. Please complete a medication error/incident report, make the MD aware and send pharmacy the correct order." There was no notation on the review that this was addressed or sent to the physician for review.

Resident #10's October MAR revealed resident received risperidone 0.5 mg one time per day from 10/1/23 through 10/31/23.

Review of a 10/20/22 document titled Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response revealed a recommendation which read: "This consult is being resent because either the response to last month's consult was either not found, not addressed, or not scanned into the electronic health record at the time of this review. The MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan." There was no notation on the review that this was addressed.

Resident #10's November MAR revealed resident received risperidone 0.5 mg one time per day from 11/1/23 through 11/30/23.

Review of a 11/17/22 document titled Consultant Pharmacist's Medication Regimen Review Active

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F 756

Recommendations Lacking a Final Response revealed a recommendation which read: "This consult is being resent because either the response to last month's consult was either not found, not addressed, or not scanned into the electronic health record at the time of this review. The MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan." There was no notation on the review that this was addressed. There was no documentation in Resident #10's electronic health record regarding the recommendation.

Resident #10's December MAR revealed resident received risperidone 0.5 mg one time per day from 12/1/23 through 12/31/23.

Review of a 12/15/22 document titled Note to Attending Physician/Prescriber which read in part: please review the dose of risperidone at this time for potential discontinuation due to change in movements. The above was originally recommended in August 2022. Provider response was uploaded to the chart stated to reduce the risperidone to 0.25 mg once daily, but this was not carried out. Resident continues to receive risperidone 0.5 mg once daily. Please consider re-evaluation or document rational for continued use at current dosage. Handwritten documentation which stated faxed to MD was observed on the note with no signature or date. Physician/Prescriber response on the note was blank. There was no documentation in Resident #10's electronic health record regarding this.

Resident #10's January 2023 MAR indicated

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F 756	Continued From page 44 resident received risperidone 0.5 milligrams one time per day. Review of a 1/18/23 document titled Consultant Pharmacist's Medication Regimen Review revealed it read in part: "please review the dose of risperidone at this time for potential discontinuation due to change in movements. The above was originally recommended in August 2022. Provider response was uploaded to the chart which stated to reduce the risperidone to 0.25 mg once daily, but this was not carried out. Resident continues to receive risperidone 0.5 mg once daily. Please consider re-evaluation or document rational for continued use at current dosage." There was not documentation on the form or in the electronic health record that this was addressed. Review of a 2/19/23 pharmacy medication regimen review for Resident #10 indicated in part "Recommendation was made in August 2022 with provider response uploaded to the chart which stated to reduce risperidone to 0.25 milligrams once per day, but this was not carried out. The Resident continues to receive risperidone 0.5 milligrams once per day. Please consider reevaluation or document rationale for continued use of risperidone at current dosage. This consult was resent because either the response to last month's consult was either not found, not addressed, or not scanned into the medical record at the time of the review." The recommendation was signed as agree. A 2/23/23 DISCUS evaluation indicated a score of "3" with oral movements which included chewing/lip smacking, puckering, sucking or thrusting the lower lip and lingual movements	F 756		

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which included tongue thrusting or tongue in cheek observed. This was a decrease from the score of "4" on the DISCUS evaluation completed on 8/11/22.

A physician's order for Resident #10 dated 3/21/23 for risperidone tablet give 0.25 mg by mouth one time per day for major depressive disorder with psychotic symptoms was observed in resident's electronic health record.

Review of Resident #10's 5/22/23 quarterly Minimum Data Set assessment indicated resident had moderate cognitive impairment and exhibited no behaviors. Resident #10 received injections, an antipsychotic medication, and an antidepressant 7 days in the look back period.

Interview on 8/24/23 at 1:00 PM with the Regional Pharmacy Services Manager revealed the consultant pharmacist reviewed resident medications monthly. The Regional Pharmacy Services Manager indicated that the time frame to address pharmacy recommendations depends on the nature of the recommendation. The expectation was that the recommendations were addressed prior to the next monthly pharmacist visit and that the previous recommendation would be reviewed to be sure they were addressed. The Regional Pharmacy Services Manager stated that risperidone had a lower potential for abnormal movements but did have this as a risk.

Follow up interview on 8/24/23 at 1:45 PM with the Regional Pharmacy Services Manager indicated that the pharmacy had on record the pharmacy recommendation that was approved by the physician on 8/27/23. The Consultant Pharmacist sent recommendations to the facility

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on 9/21/22, 10/20/22, 11/17/22, 12/15/22 and 1/18/23 and 2/20/23 for follow up and clarification of the order to decrease Resident #10's risperidone per the 8/22/23 recommendation. These recommendations were not addressed.

An interview was conducted on 8/24/23 at 3:45 PM with the Nursing Supervisor. The Nursing Supervisor stated that the pharmacy recommendations were sent to the physician by the DON or ADON. The Nursing Supervisor stated that the physician made rounds in the facility and addressed the pharmacy recommendations at that time. The Nursing Supervisor stated she tried to make sure the orders were carried out when the physician addresses them. The Nursing Supervisor acknowledged she wrote the order on 8/28/22 to decrease Resident #10's risperidone per the signed pharmacy recommendation. The Nursing Supervisor further acknowledged she signed off the order which indicated she carried out the order meaning it was sent to the pharmacy and transcribed in Resident #10's electronic health record. The Nursing Supervisor revealed that nursing recommendations from the pharmacist were addressed by the DON. The Nursing Supervisor stated she addressed the physician recommendations.

An interview was conducted on 8/25/23 at 10:01 AM with the Director of Nursing (DON). The DON stated the pharmacy recommendations were sent to her or the Administrator. The DON stated when she received the recommendations, she addressed them or gave them to the physician for review. The Nursing Supervisor sent the recommendations to the physician. If the recommendations were not addressed by the

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F 756	Continued From page 47 physician prior to the next monthly pharmacist review, the pharmacist wrote a follow up recommendation to address. The DON revealed she had a process of keeping the pharmacist recommendations in a book and when the recommendation was addressed by the physician a folded copy was placed in the book. The DON did not indicate that there was a process to review the recommendations to ensure all of them were addressed. The DON stated she did not think Resident #10 experienced changes related to receiving the increased dose of risperidone. The DON stated she could not tell why the physician order written on 8/27/22 on the August pharmacy recommendation was not carried out other than careless oversight. Interview on 8/25/23 at 3:00 PM with the physician revealed he was not made aware that the order to decrease risperidone for this resident was not carried out when he wrote it on 8/27/22. The physician stated he had not seen any other pharmacy recommendations regarding the medication risperidone not being carried out. The gradual dose reduction should have been completed to ensure resident received the lowest effective dose. The physician stated he expected that staff would carry out orders as written. Follow up interview with the DON on 8/25/23 at 3:50 PM revealed she looked for the pharmacy recommendations to see what happened with the nursing recommendations that were written for this resident from August 2022 through present. The DON located copies of the Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response dated 10/20/22 and a note to the Attending Physician/Prescriber dated 12/11/22. The DON	F 756		

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was unable to locate other pharmacy recommendations that were sent to the facility for Resident #10. The DON was unable to state why the pharmacy recommendations for Resident #10 were not addressed other than human error.

The facility provided the following Corrective Action Plan with a completion date of 7/31/23:

1. The facility identified the following system issue regarding documentation of psychotropic medications which indicated in part:
Orders were not transcribed/initiated timely.
Pharmacist recommendations to the physician were not completed timely.
Pharmacist recommendation to nursing were not completed timely.
Concerns identified during a pharmacy review were not addressed/corrected by the facility which included medication concerns.

2. An audit was conducted by the Director of Nursing (DON) of all pharmacy recommendations for the past 90 days. All concerns identified were addressed by 7/31/23.

3. The Staff Development Coordinator and DON educated the Medical Director and all physicians regarding completion of the pharmacy recommendations timely to include rationale when declining recommendations. This education was completed by 7/31/23.

The Staff Development Coordinator educated all nurses regarding pharmacy recommendations with emphasis on ensuring the physician recommendations were reviewed by the physician timely and all new orders were transcribed

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F 756	Continued From page 49 accurately. This education was completed by 7/31/23. The facility consultant educated the DON on 7/17/23 regarding pharmacy recommendations which included ensuring all recommendations were completed timely and accurately. 4.On 7/17/23 it was determined that as part of the plan of correction, a 10% audit of all Pharmacy Recommendations will be completed by the Quality Assurance nurse monthly for 3 months using an audit tool to ensure all recommendations were reviewed and completed timely and accurately. 5. On 7/17/23 it was determined that as part of the plan of correction, the pharmacy recommendation audit tool will be presented at the Quality Assurance and Performance Improvement (QAPI) meeting monthly for 3 months. The Corrective Action Plan was validated on 8/25/23 and concluded the facility had implemented an acceptable corrective action plan on 7/31/23. Interviews with the nursing staff, revealed the facility had provided education and training regarding pharmacy recommendations. Review of the monitoring tools that began on 7/17/23 revealed the tools were completed as outlined in the corrective action plan with no concerns identified.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		9/25/23

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F 758	Continued From page 50	F 758		

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and

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F 758	Continued From page 51 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician, and Regional Pharmacy Services Manager interviews the facility failed to transcribe and administer an antipsychotic medication at a reduced dose per the Consultant Pharmacist recommendation due to a noted increase in abnormal movements. The failure to transcribe the reduced dose resulted in 189 doses administered at a higher dose than ordered for 1 of 5 residents (Resident #10) reviewed for psychotropic medication. Findings included: Resident #10 was admitted to the facility on 11/16/20 with medical diagnoses which included in part: dementia with behaviors and major depression with psychoses. Review of Resident #10's care plan revealed a 5/18/21 focus, last revised on 5/24/23, of use of psychotropic drugs with potential for side effects of involuntary movements related to use of antipsychotic medication with a goal of no side effects from medication regimen. The interventions included administer medications per physician order and DISCUS (Dyskinesia Identification System Condensed User Scale- an exam used to identify involuntary movements of the tongue, lips, eyes, upper and lower limbs associated with psychotropic drug use).	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use On 3/21/23, the Director of Nursing clarified the Risperdal medication order for resident #10. The order was updated in the electronic record per physician order. On 9/8/23, the assigned nurse completed the Dyskinesia Identification System Condensed User Scale (DISCUS) assessment for resident #10 with a score level of 2 with no adverse effects noted. The physician was notified of updated assessment. On 9/13/23 the pharmacy consultant initiated an audit of all pharmacy recommendations for the past 60 days. This audit is to ensure the physician reviewed recommendations and all provider recommendations/orders were transcribed accurately to the electronic record to include but not limited to psychotropic medications. The Director of Nursing and Assistant Director of Nursing will address all concerns identified during the audit to include initiating orders when indicated, assessment of the resident, notification of the physician for further	

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Review of an 8/17/22 pharmacy recommendation note to Resident #10's physician indicated a recent DISCUS showed worsening abnormal voluntary movements with an increase in the scoring of the exam from 1 on 5/5/22 to 4 on 8/11/22.. The note read in part: "Please review the dose of risperidone at this time for potential discontinuation due to change in movements." The physician signed the recommendation on 8/27/22 indicating agreement with the recommendation and wrote an order on the recommendation for a dose reduction of Resident #10's risperidone dose from 0.5 milligrams once per day to 0.25 milligrams once per day. There was no documentation that this order was signed off by a nurse.

Resident #10's August and September Medication Administration Records (MAR) revealed resident received risperidone 0.5 milligram (mg.) one time per day from 8/17/22 through 9/20/22. This resulted in the resident receiving 35 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone.

Review of a 9/21/22 document titled Consultant Pharmacist's Medication Regimen Review read "the MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan. Please complete a medication error/incident report, make the MD aware and send pharmacy the correct order." There was no notation on the review that this was addressed or sent to the physician for review. The review contained no documentation that it was reviewed or signed off by the physician or a nurse.

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recommendations and/or education of staff. The audit will be completed by 9/25/23.

On 8/29/23, the Staff Facilitator initiated an in-service with all nurses regarding (1)Transcribing Orders with emphasis on ensuring medications are transcribed accurately to the electronic record and given per physician orders to include use of a 2-check system when entering new orders to ensure accuracy (2) Pharmacy Recommendations with emphasis on ensuring physician recommendations are reviewed by the physician timely and all new orders transcribed accurately and administered per physician orders utilizing a two-nurse check system and that all nursing recommendations are completed timely or referred to the physician for further recommendations when indicated with documentation in the electronic record. In-services will be completed by 9/25/23. After 9/25/23, any nurse who has not worked or received the in-service will receive upon next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Transcribing Orders and Pharmacy Recommendations

On 9/13/23, the Administrator completed an in-service with the DON regarding Pharmacy Recommendations with emphasis on responsibility to ensure pharmacy recommendations are completed timely and new orders initiated per physician recommendations.

10% audit of all pharmacy

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Resident #10's September 2022 and October 2022 Medication Administration Records (MAR) revealed resident received risperidone 0.5 mg. one time per day from 9/21/22 through 10/20/22. This resulted in the resident receiving 30 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone.

Review of a 10/20/22 document titled Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response revealed a recommendation which read: "This consult is being resent because either the response to last month's consult was either not found, not addressed, or not scanned into the electronic health record at the time of this review. The MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan." There was no notation on the review that this was addressed. The review contained no documentation that it was reviewed or signed off by the physician or a nurse.

Resident #10's October 2022 and November 2022 MAR revealed resident received risperidone 0.5 mg one time per day from 10/20/22 through 11/17/22. This resulted in the resident receiving 29 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone.

Review of a 11/17/22 document titled Consultant Pharmacist's Medication Regimen Review Active Recommendations Lacking a Final Response revealed a recommendation which read: "This consult is being resent because either the response to last month's consult was either not

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recommendations will be completed by the Assistant Director of Nursing (DON), Staff Facilitator and Minimum Data Set Nurse (MDS) to ensure all recommendations to include recommendations for changes in psychotropic medications were followed per physician□s approval monthly x 3 months utilizing the Pharmacy Recommendation Audit Tool. The physician will be notified of any areas of concern during the audit by the ADON, Staff Facilitator and or MDS nurse.
The Administrator will review the Pharmacy Recommendation Audit Tool monthly x 3 months to ensure all areas of concern are addressed.

The Director of Nursing will forward the Pharmacy Recommendation Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will meet monthly for three (3) months and review the Pharmacy Recommendation Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

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F 758	Continued From page 54 found, not addressed, or not scanned into the electronic health record at the time of this review. The MD agreed to reduce the risperidone dose due to worsening movements. I do not see that the order was carried out and I don't see an explanation as to why there was a change in plan." There was no notation on the review that this was addressed. There was no documentation in Resident #10's electronic health record regarding the recommendation. The review contained no documentation that it was reviewed or signed off by the physician or a nurse. Resident #10's November 2022 and December 2022 MAR revealed resident received risperidone 0.5 mg one time per day from 11/17/22 through 12/15/22. This resulted in the resident receiving 29 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone. Review of a 12/15/22 document titled Note to Attending Physician/Prescriber which read in part: please review the dose of risperidone at this time for potential discontinuation due to change in movements. The above was originally recommended in August 2022. Provider response was uploaded to the chart stated to reduce the risperidone to 0.25 mg once daily, but this was not carried out. Resident continues to receive risperidone 0.5 mg once daily. Please consider re-evaluation or document rational for continued use at current dosage. Handwritten documentation which stated faxed to MD was observed on the note with no signature or date. Physician/Prescriber response on the note was blank. There was no documentation in Resident #10's electronic health record regarding this. The review contained no documentation that it was	F 758		

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reviewed or signed off by the physician or a nurse.

Resident #10's December 2022 and January 2023MAR revealed resident received risperidone 0.5 mg one time per day from 12/15/22 through 1/18/22. This resulted in the resident receiving 34 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone.

Review of a 1/18/23 document titled Consultant Pharmacist's Medication Regimen Review revealed it read in part: "please review the dose of risperidone at this time for potential discontinuation due to change in movements. The above was originally recommended in August 2022. Provider response was uploaded to the chart which stated to reduce the risperidone to 0.25 mg once daily, but this was not carried out. Resident continues to receive risperidone 0.5 mg once daily. Please consider re-evaluation or document rational for continued use at current dosage." There was not documentation on the form or in the electronic health record that this was addressed. The review contained no documentation that it was reviewed or signed off by the physician or a nurse.

Resident #10's January 2023 and February 2023 MAR indicated resident received risperidone 0.5 milligrams one time per day from 1/18/23 through 2/19/23. This resulted in the resident receiving 32 doses of Risperidone at 0.5 mg when he should have received 0.25 mg of Risperidone.

Review of a 2/19/23 pharmacy medication regimen review for Resident #10 indicated in part "Recommendation was made in August 2022 with provider response uploaded to the chart which

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stated to reduce risperidone to 0.25 milligrams once per day, but this was not carried out. The Resident continues to receive risperidone 0.5 milligrams once per day. Please consider reevaluation or document rationale for continued use of risperidone at current dosage. This consult was resent because either the response to last month's consult was either not found, not addressed, or not scanned into the medical record at the time of the review." The recommendation was signed by the physician as agree. The review contained no documentation that it was reviewed or signed off by a nurse.

A 2/23/23 DISCUS evaluation indicated a score of "3" with oral movements which included chewing/lip smacking, puckering, sucking or thrusting the lower lip and lingual movements which included tongue thrusting or tongue in cheek observed. This was a decrease from the score of "4" on the DISCUS evaluation completed on 8/11/22.

A physician's order for Resident #10 dated 3/21/23 for risperidone tablet give 0.25 mg by mouth one time per day for major depressive disorder with psychotic symptoms was observed in resident's electronic health record.

A review of Resident #10's March 2023 MAR indicated risperidone 0.25 mg. one time per day was started on 3/21/23 and administered through 3/31/23.

Review of Resident #10's 4/4/23 quarterly Minimum Data Set (MDS) assessment indicated resident had moderate cognitive impairment and exhibited no behaviors. Resident #10 received an antipsychotic medication 7 days in the look

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back period.

Interview on 8/24/23 at 1:45 PM with the Regional Pharmacy Services Manager indicated the pharmacy had on record the pharmacy recommendation for a dose reduction of risperidone which was approved by the physician on 8/27/23. The Consultant Pharmacist sent recommendations to the facility on 9/21/22, 10/20/22, 11/17/22, 12/15/22 and 1/18/23 and 2/20/23 requesting follow up and clarification of the dose reduction to decrease Resident #10's risperidone per the 8/22/23 recommendation. These recommendations were not addressed by the physician or a nurse. The Regional Pharmacy Services Manager stated risperidone had the potential for abnormal movements which can be severe and gradual dose reduction was necessary to avoid these movements.

An interview was conducted on 8/24/23 at 3:45 PM with the Nursing Supervisor. The Nursing Supervisor stated she tried to make sure the orders were carried out when the physician addressed them. The Nursing Supervisor acknowledged she transcribed the order on 8/28/22 to decrease Resident #10's risperidone per the pharmacy recommendation which was signed by the physician. The Nursing Supervisor further acknowledged she signed off the written order indicating she carried out the order which meant she sent order to the pharmacy and transcribed it in Resident #10's electronic health record so it would transfer to the MAR. The Nursing Supervisor stated she did not know why she did not send the order for the dose reduction to the pharmacy and did not enter it in Resident #10's electronic health record. The Nursing

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Supervisor stated it was human error that she did not carry out the order for the dose reduction for Resident #10 as written by the physician.

An interview was conducted on 8/25/23 at 10:01 AM with the Director of Nursing (DON). The DON stated the pharmacy recommendations were sent to her or the Administrator and when she received them, she addressed them or gave them to the physician for review. The DON acknowledged the recommendations that were not addressed by the physician prior to the next monthly pharmacist review received a written follow up recommendation to address. The DON stated the follow up recommendations should have been addressed. The DON stated she did not think Resident #10 experienced changes related to the increased dose of risperidone however she indicated dose reductions were important to lessen the likelihood of permanent effects. The DON stated she could not tell why the physician order written on 8/27/22 on the August pharmacy recommendation was not carried out other than careless oversight.

Interview on 8/25/23 at 3:00 PM with the physician revealed he was not made aware that the order to decrease risperidone for this resident was not carried out when he wrote it on 8/27/22. The physician stated the gradual dose reduction should have been completed to ensure resident received the lowest effective dose and to avoid side effects associated with the higher dose. The physician stated he expected staff would carry out orders as written.

F 760 SS=G Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) F 760 9/25/23

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F 760	Continued From page 59 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Regional Pharmacy Manager, and Physician interviews the facility failed to: 1) administer 25 doses of a controlled substance hypnotic medication (Ambien) as prescribed for the treatment of insomnia resulting in decreased sleep, restlessness, and anxiety (Resident #84, and Resident #6); 2) administer 4 doses of a controlled substance antianxiety medication (Temazepam) as prescribed for the treatment of insomnia resulting in decreased sleep and fear of withdrawal (Resident #31); 3) ensure the correct dose of a controlled substance medication (Dronabinol) was administered as prescribed for an appetite stimulant (Resident#256); and 4) ensure the correct dose of antianxiety medication was administered in accordance with the physician's order (Resident #62) for 5 of 5 residents reviewed for medication administration. Findings included. 1a) Resident #84 was admitted to the facility on 03/06/23 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Insomnia. A physicians order dated 03/06/23 for Resident #84 revealed an order for Ambien 10 milligram (mg) tablets. Administer one tablet by mouth at bedtime for Insomnia. The Minimum Data Set (MDS) admission assessment dated 03/13/23 revealed Resident	F 760	F760 Free of Significant Med Errors On 9/12/23, the Assistant Director of Nursing (ADON) reviewed the medication administration record from 8/25/23 to 9/11/23 for use of hypnotic medication (Ambien) for resident #84. The medication was given per physician order with no additional concerns identified. On 9/12/23, the Assistant Director of Nursing (ADON)reviewed the medication administration record from 8/25/23 to 9/11/23 for use of hypnotic medication (Ambien) for resident #6. The medication was given per physician order with no additional concerns identified. On 9/12/23, the Assistant Director of Nursing (ADON) reviewed the medication administration record from 8/25/23 to 9/11/23 for use of anxiety medication (Temazepam) for resident #31. The medication was given per physician order with no additional concerns identified. On 9/11/23, the appetite stimulant (Dronabinol) for resident #256 was discontinued and Remeron initiated per physician�s order for appetite stimulant. The order was transcribed to the electronic medication record and given per physician�s order with no additional concerns identified.	

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#84 was cognitively intact. She required supervision with bed mobility, transfers, and activities of daily living (ADLs). She received scheduled hypnotics on 4 of 7 days during the assessment period.

A care plan dated 03/15/23 revealed Resident #84 received psychotropic and hypnotic medications. The interventions included in part; to administer medications per the physicians order.

Review of Resident #84's March 2023 Medication Administration Record (MAR) revealed on 3/10, 3/17, 3/18, 3/19, 3/22, 3/24, 3/26, 3/28, and 3/30, Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of Resident #84's April 2023 Medication Administration Record (MAR) revealed on 4/19, 4/20, 4/21, and 4/23, the Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of the Controlled Substance Count Record for Resident #84 for March 2023 and April 2023 revealed the entries made by staff were not legible and it could not be determined if the dose was signed out on the declining count record.

Review of the nursing progress notes dated 03/10/23 through 04/23/23 revealed no documentation as to why the Ambien 10 mg tablets were not available and were not administered to Resident #84. .

During an interview on 08/23/23 03:03 PM Resident #84 was observed lying in bed in her room. She was alert and oriented. She stated she needed the Ambien each night for sleep and

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On 2/22/23, the anxiolytic (Buspar) order for resident #62 was clarified with physician and the electronic record updated to reflect accurate dosing. On 9/12/23 the Assistant Director of Nursing reviewed the medication administration record from 8/25/23-9/11/23 for use of anxiolytic (Buspar) for resident #62. The medications was given per physician order with no additional concerns.

On 9/13/23, the ADON, Director of Nursing (DON), Nurse Supervisor and Staff Facilitator initiated an audit of all medication carts to ensure medications are available to be administered per physician order to include right medication, right dose and right frequency. The ADON, Director of Nursing (DON), Nurse Supervisor and Staff Facilitator will address all concerns identified during the audit to include notification of the physician/pharmacy for refill orders when indicated and/or obtaining medications from back up pharmacy when indicated. The audit will be completed by 9/25/23.

On 9/13/23, the ADON initiated an audit of all medications listed as not available to administer from 8/25/23 to 9/12/23. This audit is to ensure medications are available and administered per physician order. The ADON, Nurse Supervisor, Staff Facilitator and DON will address all concerns identified during the audit to include obtaining medications from pharmacy and/or notification of the

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stated she went for a period of time a few months ago when the medication was not available, but she could not recall a specific date or time. She stated she was only told the medication was not available from the pharmacy. She stated when she didn't take the nightly dose of Ambien, she had trouble sleeping. She stated she did not get good sleep when she didn't take the medication and during that time, she would eventually fall asleep late around 2:00 -3:00 AM and then she would wake up several times during the night which caused her to be tired the following day. She stated it would also cause her to be anxious from not getting sleep, but stated she did not take medication for anxiety. She stated she didn't feel great most days and without taking Ambien and getting sleep it made her feel worse and it made her not want to get out of bed.

During a phone interview on 08/24/23 at 01:53 PM the Regional Pharmacy Services Manager stated the pharmacy was not aware of any issue with Resident #84's Ambien until they were notified by the facility on 04/21/23. He stated upon investigation their records showed that thirty Ambien 10 mg tablets were dispensed to the facility for Resident #84 on 03/13/23, and thirty tablets were dispensed to the facility on 03/19/23, and thirty tablets were dispensed to the facility on 04/10/23. He stated the facility should have had the medication on hand and available for Resident #84 on the specified dates.

Review of the Monthly Consultant Pharmacist reports revealed no documentation regarding Resident #84's Ambien. The Pharmacy Consultant that conducted the monthly review was not available for interview during the survey period.

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physician for further recommendations when medication cannot be obtained. The audit will be completed by 9/25/23.

On 9/13/23, the pharmacy consultant initiated an audit of all pharmacy recommendations for the past 60 days. This audit is to ensure the physician reviewed recommendations and all provider recommendations/orders were transcribed accurately to the electronic record to include but not limited to psychotropic medications. The ADON, DON, Staff Facilitator and Nurse Supervisor will address all concerns identified during the audit to include initiating orders when indicated, assessment of the resident, notification of the physician for further recommendations and/or education of staff. The audit will be completed by 9/25/23.

On 8/25/23, the Staff Facilitator initiated Medication Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aide followed the Rights of Medication Administration and physician order when administering medications. Rights to Medication Administration included but not limited to the right medication, right dose, right route, right time to the right resident and using a three-check system when administering medications to include checking medication to medication administration record (MAR) prior to administering. The Staff Facilitator will address all concerns identified during the audit to include education of the nurse.

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b.) Resident #6 was admitted to the facility on 11/10/22 with diagnoses including Heart Failure, Diabetes, and Insomnia.

A care plan dated 11/21/22 revealed Resident #6 received psychotropic and hypnotic medications. The interventions included in part; to administer medications per the physicians order.

A physicians order for Resident #6 dated 12/05/22 revealed Zolpidem Tartrate (Ambien) Oral Tablet 10 mgs. Give 10 mgs by mouth at bedtime for insomnia.

Review of Resident #6's March 2023 Medication Administration Record (MAR) revealed on 3/3, ¾, 3/5, 3/6, 3/8, 3/10, 3/13, and 3/16, Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of Resident #6's April 2023 Medication Administration Record (MAR) revealed on 4/2, 4/19, 4/20, 4/21, Ambien 10 mg tablets were documented on the MAR as not available for administration.

Review of the Controlled Substance Count Record for Resident #6 for March 2023 and April 2023 revealed the entries made by staff were not legible and it could not be determined if the dose was signed out on the declining count record.

A progress noted dated 04/02/23 at 8:00 PM documented by Nurse #6 revealed Ambien was not available. Resident was made aware and admitted that chronic pain kept her awake at night and will take her available Tramadol for back pain, (pain scale) 5 out of 10 which will also help

Medication Pass Audits will be completed by 9/25/23. After 9/25/23, any nurse who has not completed the audit will complete upon next scheduled work shift. All newly hired nurses will complete a Medication Pass Audit during orientation.

On 8/29/23, the Staff Facilitator initiated an in-service with all nurses regarding (1) Obtaining Medications with emphasis on ordering medications timely to ensure medication available to administer per physician order, obtaining medications from eKit or back up pharmacy and notification of the physician when medications cannot be obtained for further instructions and/or alternative medication with documentation in the electronic record of all physician recommendations when indicated. (2) Pharmacy Recommendations with emphasis on ensuring physician recommendations are reviewed by the physician timely and all new orders transcribed accurately and administered per physician orders utilizing a two-nurse check system and that all nursing recommendations are completed timely or referred to the physician for further recommendations when indicated with documentation in the electronic record. The in-service will be completed by 9/25/23. After 9/25/23, any nurse who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Obtaining Medications and Pharmacy Recommendations.

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her to sleep with pain relief.

During the investigation an attempt was made to contact Nurse #6 on 08/25/23 with no response.

Further review of the nursing progress notes dated 03/03/23 through 04/21/23 revealed no documentation as to why the Ambien 10 mg tablets were not available and were not administered to Resident #6.

The Minimum Data Set (MDS) most recent quarterly assessment dated 06/26/23 revealed Resident #6 was cognitively intact. She required extensive one-to-two-person assistance with bed mobility, transfers, and activities of daily living (ADLs). She received hypnotics during the assessment period.

During an interview on 08/23/23 at 3:00 PM Resident #6 was observed lying in bed in her room. She was alert and oriented. She stated there was a period of time a few months ago when she was not receiving her nightly dose of Ambien. She stated she was only told the medication was not available from pharmacy. She stated not getting the Ambien each night caused her to not fall asleep, or if she dozed off, she would not stay asleep. She stated she was up all hours of the night during that time and would have to watch TV during the night at 3 or 4:00 AM just to try to go to sleep. She stated she took Tramadol as needed for pain and had to take pain medication on some of those nights to relax enough to help her get to sleep. She stated she stayed in bed most of the time regardless of her medications but stated on the nights she wasn't sleeping due to not getting the Ambien, it made her feel more tired and restless during the day.

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On 8/29/23, the Staff Facilitator initiated an in-service for all nurses and med aides on the Rights of Medication Administration with emphasis on ensuring the resident receives the right medication, at the right time, right route, right dose and to ensure staff notify the physician for any discrepancies for clarification. The in-service will be completed on 9/25/23. After 9/25/23 and any nurse or medication aide who has not received the in-service will complete the in-service prior to the next scheduled shift . All newly hired nurses and medication aides will be in-service during orientation regarding. The Unit Managers, Assistant Director of Nursing (ADON) and/or Nurse Supervisor will review the Orders Listing Report for medications not administered 5 times a week x 4 weeks then monthly x 1 month to ensure medications were available and administered per physician orders. The Unit Managers, ADON and/or Nurse Supervisor will address all concerns identified during the audit to include obtaining medications when indicated, notification of the physician when medications cannot be obtained for further instructions with documentation in the electronic record and/or re-training of staff. The Director of Nursing (DON) will review the Orders Listing Report weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

10% audit of all pharmacy recommendations will be completed by the Assistant Director of Nursing (DON), Staff Facilitator and Minimum Data Set

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During a phone interview on 08/24/23 at 01:53 PM the Regional Pharmacy Services Manager stated the pharmacy was not aware of any issue with Resident #6's Ambien until they were notified by the facility on 04/21/23. He stated upon investigation their records showed that on 01/20/23 the pharmacy dispensed to the facility thirty tablets of Ambien 10 mgs. On 03/17/23 the pharmacy dispensed thirty tablets of Ambien 10 mgs. On 03/29/23 the pharmacy dispensed five tablets of Ambien 10 mgs, then on 04/03/23 the pharmacy dispensed thirty Ambien 10 mg tablets. He stated the facility should have had the medication on hand and available for Resident #6 on the specified dates.

Review of the Monthly Consultant Pharmacist reports revealed no documentation regarding Resident #6's Ambien. The Pharmacy Consultant that conducted the monthly review was not available for interview during the survey period.

During an interview on 08/24/23 at 07:21 AM the Administrator stated that on 04/21/23 the Nursing Supervisor was responsible for the medication cart that contained Resident #84 and Resident #6's medications due to a staff member not showing up for work that morning. She stated the Nursing Supervisor thought the narcotic count sheet didn't look right and she reported this to her. She stated they immediately started an investigation and determined the Ambien for Resident #84 and Resident #6 was missing. She stated a full investigation was completed. She contacted the pharmacy and obtained dispensing records and determined that no Ambien was returned to the pharmacy for Resident #84 or Resident #6. She stated she and the Nursing

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Nurse (MDS) to ensure all recommendations to include recommendations for changes in psychotropic medications were followed per physician□s approval monthly x 3 months utilizing the Pharmacy Recommendation Audit Tool. The physician will be notified of any areas of concern during the audit by the Assistant Director of Nursing (DON), Staff Facilitator and Minimum Data Set Nurse (MDS). The DON will review the Pharmacy Recommendation Audit Tool monthly x 3 months to ensure all areas of concern are addressed.

The Staff Facilitator will complete 5 Medication Pass Audits with nurses and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aide followed physician orders and the Rights of Medication Administration with administering medications. Rights to Medication Administration included but not limited to the right medication, right dose, right route, right time to the right resident and using a three-check system when administering medications to include checking medication to medication administration record (MAR) prior to administering medications. The Staff Facilitator will address all concerns identified during the audit to include re-training of the nurse. The Administrator will review the Medication Pass Audits weekly x 4 weeks to ensure all concerns are addressed.

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F 760	Continued From page 65 Supervisor were unaware until that time that Resident #84 or Resident #6 was not getting the nightly dose of Ambien. During an interview on 08/24/23 at 11:42 AM the Nursing Supervisor stated on 04/21/23 a Medication Aide was assigned to Resident #84 and Resident #6's medication cart due to a staff member not showing up for work that morning. She indicated she could not recall which Medication Aide was on the cart that morning. She stated the medication aide on duty put the declining inventory sheet (Controlled Substance Count Record)in her box at the nurses station that morning. When she looked at the declining inventory sheet it was not legible and didn't look right and she immediately reported this to the Administrator. She stated she checked the medication cart at that time and there was no Ambien available on the cart for Resident #84 or Resident #6. She stated they conducted a full investigation and determined the medication was missing because it had been dispensed from pharmacy and should have been on hand. She stated that was why Resident #84 and Resident #6 did not receive the nightly dose of Ambien on the dates specified. She stated the medication ordering process included that if a medication was not available for administration the nurse could reorder through the electronic medical record if there were refills available. She stated if no refills were available the nurse would complete a handwritten order form, and give it to her, and she would call the physician to get a new order. She stated for controlled medications the physician's office would send the order directly to the pharmacy. She stated no staff had reported to her during that time from 03/10/23 through 04/23/23 that this medication was not available	F 760	The Director of Nursing will forward the Orders Listing Report, Pharmacy Recommendation Audit Tool, and Medication Pass Audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Orders Listing Report, Pharmacy Recommendation Audit Tool, and Medication Pass Audits to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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and that was why they didn't catch the discrepancy sooner. She stated the nurses should not continue to document on the MAR that a medication was not available without following up on the medication order with the pharmacy or by notifying her so that she could get the medication sent to the facility. She stated staff needed to get better with follow-up when medications were not available for administration. She stated she did not recall getting any reports from Resident #84 or Resident #6 or from staff regarding any adverse effects from not receiving the medications but stated she believed Resident #84 and Resident #6 would have trouble sleeping without getting the nightly dose of Ambien.

During an interview on 08/24/23 at 12:30 PM the Director of Nursing (DON) indicated the Nursing Supervisor was responsible for reordering medications. She stated an investigation was conducted regarding Resident #84 and Resident #6's Ambien. She indicated the Nursing Supervisor could provide the details regarding the Residents not receiving the Ambien.

During an interview on 08/24/23 at 4:00 PM Nurse #1 stated she typically worked the day and evening shift and was assigned to Resident #84 and Resident #6 routinely. She stated there was an issue in April 2023 that was investigated by the facility regarding missing Ambien for both Residents. She stated that if she documented on the MAR that the medication was unavailable that meant it was not on the medication cart when it was scheduled to be given. She stated typically when a medication was not available, she would either reorder through the electronic medical record or complete an order form and send it to the Nursing Supervisor who would get it ordered.

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She stated she could not recall if or when she notified the Nursing Supervisor that Resident #84's or Resident #6's Ambien was not available. She indicated unfortunately Resident #84, and Resident #6 did go for a while without getting the nightly dose of Ambien. She indicated she was not aware if Resident #84 or Resident #6 had any adverse effects such as not sleeping or increased anxiety on the nights that they didn't get the medication.

During a phone interview on 08/25/23 at 1:00 PM Medication Aide #1 stated she typically worked the evening shift and was routinely assigned to Resident #84 and Resident #6. She stated she recalled a period of time when both Residents did not have Ambien available. She stated an investigation was done by the facility. She stated if she documented on the MAR that the medication was unavailable that meant it was not on the medication cart at that time. She stated medications could be reordered through the electronic medical record or she would notify the Nursing Supervisor. She stated sometimes she would just notify the Nursing Supervisor verbally that a medication was out and needed to be reordered. She stated she could not recall if or when she notified the Nursing Supervisor of Resident #84 or Resident #6 not having Ambien available. She stated she did not recall if Resident #84 or Resident #6 reported any adverse effects of not receiving the medication.

During an interview on 08/25/23 at 3:30 PM Medication Aide #2 stated she typically worked the evening or night shift. She stated she was aware that Resident #84 and Resident #6 missed getting the nightly Ambien dose for a period of time. She stated she recalled an

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investigation being conducted regarding the medication. She stated if she documented on the MAR that the medication was unavailable that meant it was not on the medication cart and was not given. She stated she could not recall if she notified the Nursing Supervisor during that time that the medication was unavailable. She indicated she was not aware of any adverse effects it had on Resident #84 or Resident #6 when they didn't get the medication.

During an interview on 08/25/23 at 4:00 PM Nurse #4 stated he routinely worked the evening and night shift and was familiar with Resident #84 and Resident #6. He stated he could not recall the details regarding the missing Ambien. He stated if he documented the medication was not available on the MAR then it was not on the medication cart at that time and was not administered.

During a phone interview on 08/25/23 at 4:30 PM Nurse #5 stated she only worked as needed and could not recall any details regarding Resident #84 or Residents #6's Ambien. She stated if she documented on the MAR that the medication was not available that meant it was not on the medication cart at that time and it was not given.

During a phone interview on 08/25/23 at 5:00 PM Physician #1 stated she did not recall the details of Resident #84's or Resident #6's missing Ambien. She stated the facility most likely made her aware of the issue regarding the Ambien but stated she knew they had resolved the concern. She stated Resident #84 or Resident #6 not getting the nightly dose of Ambien would cause difficulty sleeping. She stated she did not recall any reported concerns made by staff of increased

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anxiety or restlessness regarding Resident #84 or Resident #6 but they most likely were not sleeping well during that time.

During an interview on 08/25/23 at 5:00 PM the Administrator stated during the time that staff were documenting the Ambien medication was unavailable that staff should have followed up sooner with the Nursing Supervisor. She stated Resident #84 or Resident #6 should not have gone for that length of time without follow up and without receiving the medication. She indicated Resident #84, and Resident #6 most likely did experience lack of sleep during that time since the Ambien was not administered. She stated education would be provided to all nursing staff regarding medication administration.
2). Resident #31 was admitted to the facility on 1/25/21 with medical diagnosis which included insomnia.

Resident #31's medical record revealed a physician order dated 6/14/23 for temazepam (antianxiety medication) oral capsule 15 milligrams. Give 1 capsule by mouth at bedtime for insomnia.

Resident #31's August 2023 medication administration record (MAR) revealed that on 8/15/23, 8/16/23, 8/17/23 and 8/18/23 the documentation for temazepam was charted as 10 which indicated that the medication was not administered due to not available.

Interview with Resident #31 on 8/21/23 at 12:45 PM revealed she did not receive her sleep medication for several nights due to it was not available in the facility. Resident #31 stated she was upset the nights she did not receive the

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medication because she could not sleep and feared she was going to have withdrawals.

Review of the Controlled Substance Count Record for Resident #31 revealed a count sheet dated 8/18/23 for temazepam 15 milligrams. The count sheet indicated 30 tablets sent by pharmacy on 8/18/23.

Interview on 8/23/23/ at 1:00 PM with Nurse #1 revealed she was assigned to Resident #31 on the evening of 8/16/23 until 11:00 PM. Nurse #1 indicated documentation of 10 on the MAR meant that the medication temazepam was unavailable. Nurse #1 stated that the medication temazepam was not in the medication cart on 8/16/23 and was not in the facility, so she did not administer it and documented 10 on the MAR. Nurse #1 revealed that she did not inform the physician that the medication was unavailable and did not attempt to obtain the medication. Nurse #1 stated she had worked at the facility for several years and knew she was supposed to obtain the medication or inform the physician it was unavailable, but she did not do so.

Interview with Nurse #2 on 8/23/23 at 1:18 PM revealed that if the supply of a medication was getting low the nurse was to call the pharmacy, order the medication on the computer or fax the refill request to the pharmacy. Nurse #2 indicated she thought temazepam was refilled without a new prescription, but she was not sure. Nurse #2 indicated the pharmacy delivered the medication that night if ordered before 4 PM. If it was requested after 4 PM, the medication was received the next night. Nurse #2 indicated the facility had an emergency kit that contained some medications, including pain medication. Nurse #2

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stated temazepam was not included in the emergency kit. Nurse #3 stated that if a medication was not available, she did not give it. Nurse #2 sometimes it was recorded on the report sheet if a medication was not available for someone to follow up. Nurse #2 recalled that Resident #31 was out of the medication temazepam recently, but she did not know why or how that happened. Nurse #2 stated that documentation of 10 on the MAR indicated the medication was not administered due to it was not available.

Interview on 8/23/23 at 4:14 PM with MDS Nurse #2 revealed she was assigned to Resident #31 on the 3:00 PM -11:00 PM shift on 8/18/23. MDS Nurse #2 indicated she did not usually work the medication cart and when she did, she worked different assignments. MDS Nurse #2 stated she was not familiar with Resident #31's usual sleep patterns. MDS Nurse stated if any of the nurses noticed that a medication was running low, they could request a refill from the pharmacy. MDS Nurse #2 stated she documented a 10 on Resident #31's MAR on the evening of 8/18/23 indicating the medication was not available and she did not give it. MDS Nurse #2 stated she did not know why the medication was not available, she had not attempted to obtain it and had not notified the physician. MDS Nurse #2 revealed medication aides worked the medication carts and they don't check when refills are needed. MDS Nurse #2 stated no one was assigned to audit the medication carts for refills. MDS Nurse #2 stated she did not recall if Resident #31 was upset on 8/18/23 about not receiving her scheduled temazepam.

Interview on 8/24/23 at 5:20 AM with Nurse #3

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indicated she was assigned to Resident #31 on 8/15/23 and 8/17/23 from 7:00 PM to 7:00 AM. Nurse #3 revealed some medications required a prescription for refills. Nurse #3 stated all the nurses were supposed to send requests to the provider to obtain a prescription for refills. No one was assigned to check when refills were needed or to send the requests for refill prescriptions. Nurse #3 stated when she was assigned to Resident #31 on 8/15/23 and 8/17/23, she charted 10 on the MAR for temazepam which indicated the medication was not available in the facility and she did not give it. Nurse #3 stated she should have attempted to obtain the medication and notified the physician, but she did not do so. Nurse #3 stated she did not know why she had not done these things.

Interview on 8/24/23 at 1:00 PM with Regional Pharmacy Services Manager revealed that some residents experience insomnia and nervousness or restlessness from missing a dose of temazepam.

During a follow up interview on 8/24/23 at 1:45 PM with the Regional Pharmacy Services Manager he revealed that the last prescription for temazepam was dispensed for Resident #31 on 7/14/23 for 30 tablets. On 8/18/23 a new prescription of 30 tablets of temazepam was dispensed for Resident #31. There was no refill request received from the facility prior to 8/18/23. The pharmacy received an electronic prescription on 8/18/23 for Resident #31 for temazepam 15 milligrams give one tablet at bedtime for sleep.

An interview on 8/24/23 at 2:45 PM with the Physician revealed she was not informed that Resident #31 did not receive the ordered

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temazepam on 8/15/23, 8/16/23, 8/17/23 and 8/18/23 due to it was not available. The physician stated that it may not have affected Resident #31 to miss the scheduled doses of temazepam, but it should have been reported and the refill should have been requested before the resident ran out of medication. The physician stated the omission of a medication for insomnia for several nights could be a significant issue.

An interview was conducted on 8/24/23 at 3:49 PM with the Nursing Supervisor. The Nursing Supervisor revealed the nurses sometimes told her and she contacted the doctor's office to request a refill for a controlled substance. The Nursing Supervisor stated that on 8/18/23 she was told the refill was needed for Resident #31's temazepam and she requested the refill from the physician. The Nursing Supervisor stated there was no one assigned to check the medications on the medication cart to be sure the residents had their ordered medications. The Nursing Supervisor further stated that she was not informed until 8/18/23 that Resident #31 required a refill of her ordered temazepam.

An interview was conducted on 8/25/23 at 10:14 AM with the Director of Nursing. The DON stated the physician was to be notified in a timely manner that a new prescription was needed for a refill of a controlled substance. The DON stated the nurses should have notified the physician when they determined the medication was unavailable to determine if there was a substitute. The DON stated the Nursing Supervisor usually handled contacting the physician when refills were needed. The DON stated she did not know why the refill request was not sent prior to the medication running out.

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3). Resident #256 was admitted to the facility on 08/11/23 with medical diagnosis that included anorexia and moderate protein-calorie malnutrition.

Review of an admission MDS assessment for Resident #256 documented he had moderately impaired cognition. He received a mechanically altered, therapeutic diet and weighed 133 pounds. He was independent with eating and required set up help only.

The initial care plan for Resident #256 was in progress beginning on 08/11/23 and included guidance for activities of daily living and personal care.

Review of Resident #256 ' s weights revealed an admission weight on 08/11/23 of 132.6 pounds. On 08/23/23 he weighed 130.6 pounds for a total weight loss of 2 pounds between 08/11/23 and 08/23/23.

Resident #256 ' s medical record revealed a physician order dated 08/12/23 for Dronabinol Oral 5 MG capsule twice a day for appetite stimulant.

Review of the Controlled Substance Count Record on 08/23/23 revealed Resident #256 was administered Dronabinol one 2.5 MG capsule on 08/18/23 at 6:00 PM, 08/19/23 at 10:30 AM, 08/20/23 at 8:00 AM, 08/21/23 at 8:00 AM, 08/21/23 4:00 PM, 08/22/23 at 4:50 PM, and 08/23/23 at 8:00 AM.

Review of the bubble pack sent by pharmacy read: Dronabinol Cap 2.5 MG, take 2 capsules = 5 MG by mouth twice daily, refrigerate.

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In an interview with Resident #256 on 08/23/23 at 2:50 PM he stated some days he was hungry and some days when he felt bad, he was not hungry. He reported he had not noticed a change in his appetite since he came to the facility.

In an interview with Nurse #7 on 08/23/23 at 9:45 AM she stated she was helping the Medication Aide that morning with the medication pass and had administered medications to Resident #256. She reported she had looked at the computer which read Dronabinol one 5 MG capsule, and she went to the refrigerator and pulled one capsule out of the bubble pack without looking at the dosage on the bubble pack. She stated she did look at the name of the resident on the bubble pack and the name of the medication but not the dose. After inspecting the bubble pack, she noted the bubble pack she had removed the capsule from read: Dronabinol Cap 2.5 MG-Take 2 capsules = 5 MG by mouth twice daily.

In an interview with Medication Aide #3 on 08/23/23 at 9:45 AM she stated she had given Resident #256 one 2.5 MG capsule of Dronabinol on 08/19/23 by mistake. She noted she thought she had given the 5 MG dose because the screen on the computer read (1) 5 MG capsule but the actual medication was only 2.5 MG with instructions to give 2 capsules. She reported she had not read the label on the medication bubble pack. She stated she had only read the dosage on the computer screen. She added she had checked the resident ' s name on the medication bubble pack to ensure it was the right resident but had not looked at the dose.

In an interview with Medication Aide #4 on

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08/23/23 at 11:53 by telephone she stated she worked 12 hour shifts at the facility on weekends and floated between assignments. She did not remember looking at the dose on the Dronabinol medication bubble pack on 08/20/23 because there was a lot going on that day. She had recorded on the Controlled Substance Count Record on 08/20/23 at 8:00 AM she gave one capsule of Dronabinol.

In an interview with Nurse #8 on 08/23/23 at 12:13 PM she stated she did recall giving Resident #256 Dronabinol in the morning and in the afternoon on 08/22/23 because she had to get the medication out the refrigerator, but was not sure why she gave the correct dose of (2) 2.5 MG capsules to equal a 5 MG dose in the morning but only gave one 2.5 MG capsule in the afternoon. She noted she did remember she had given the medication twice that day.

In an interview with Nurse #1 on 08/23/23 at 12:15 PM she stated on 08/21/23 she recorded she had given Resident #256 one 2.5 MG capsule of Dronabinol. She reported she had not looked at the label on the bubble pack and had not realized it was not a 5 MG capsule because she thought previously the facility had 5 MG capsules. She noted she had not checked the dosage of the medication on the bubble pack prior to administering the medication.

A call was placed to Nurse #8 on 08/23/23 at 11:50 AM. Her mailbox was full and would not accept a message. A text message was sent on 08/23/23 at 11:52 AM to return the call. A second text message was sent on 08/25/23 at 8:21 AM with no response.

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In an interview with Physician #2 on 08/25/23 at 3:05 PM he stated there was no guarantee that Resident #256 would not have lost weight or would have gained weight if he had been given the correct dose of Dronabinol as ordered. He noted that receiving the wrong dosage of Dronabinol would not have caused the resident harm or had very much impact on the resident, but he did expect the correct dose to be administered by nursing.

In an interview with the Administrator on 08/25/23 at 3:22 PM she stated she expected the correct dosage of medications to always be administered by the nursing staff.
4. Resident #62 was admitted to the facility on 11/16/20 with diagnoses of dementia and anxiety.

A physician's order for Resident #62 dated 5/8/22 was for buspirone (a medication to treat anxiety) 5 milligram (mg) 1 tablet by mouth one time a day for anxiety.

A review of Resident #62's January 2023 Medication Administration Record (MAR) revealed documentation he was administered buspirone 5 mg 1 tablet by mouth one time a day for anxiety from 1/1/23 through 1/31/23.

A review of a New Prescription Summary for Resident #62 dated 1/23/23 provided by the Regional Pharmacy Services Manager on 8/24/23 revealed buspirone 10 mg take 1 tablet by mouth every morning for vascular dementia related anxiety. The effective date was 1/23/23.

A Consultant Pharmacist's Medication Regime Review for Resident #62 dated 2/16/23 revealed in part an electronic prescription had been sent to

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the pharmacy and Resident #62's buspirone dose was changed on 1/23/23. The pharmacy faxed this change to the facility, but this change didn't appear to have been carried out. Staff were charting the 5 mg dose as given. The follow-through documented on the form by the Director of Nursing (DON) revealed she observed staff giving one half tablet of the medication which was the correct dose of 5 mg per Resident #62's MAR. The follow through documentation by the DON was not dated.

A physician's order entered into Resident #62's medical record by the Assistant Director of Nursing (ADON) dated 2/22/23 was for "buspirone 5 mg 2 tablets by mouth one time a day for anxiety (2 tablets equaled 10 mg new order dated 2/21/23)".

A review of Resident #62's February 2023 MAR revealed documentation he received buspirone 5 mg 1 tablet by mouth one time a day for anxiety from 2/1/23 through 2/22/23. It further revealed documentation he received buspirone 5 mg 2 tablets by mouth one time a day for anxiety (2 tablets equaled 10 mg new order 2/21/23) from 2/23/23 through 2/28/23.

A review of Resident #62's quarterly Minimum Data Set (MDS) dated 8/3/23 revealed he was severely cognitively impaired. He had no hallucinations, delusions, or behaviors. He did not reject care. He received antipsychotic, antianxiety and antidepressant medication on 7 of 7 look-back period days. Antipsychotic medication was received only on a routine basis. The physician documented a gradual dose reduction as clinically contraindicated on 7/27/23.

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A review of Resident #62's current comprehensive care plan revealed a focus area last revised on 5/10/23 of psychotropic drug use. The goal was for Resident #62 to have no side effects of medication through the next review. An intervention was to administer medications per the physician's order.

On 8/24/23 at 9:24 AM a telephone interview with the facility Regional Pharmacy Services Manager indicated the pharmacy received an electronic prescription for Resident #62 on 1/23/23 for buspirone 10 mg take 1 tablet by mouth every morning for vascular dementia related anxiety. He stated when an electronic prescription came directly to the pharmacy, the pharmacy faxed this information to the facility so the facility could enter it into their order system as the pharmacy did not have that capability. He went on to say the pharmacy sent 10 mg buspirone tablets to the facility for Resident #62 on 1/23/23. He further indicated buspirone was not a medication that would cause harm to Resident #62 if administered after being cut in half.

On 8/24/23 at 10:09 AM an interview with the DON indicated she conducted an observation of Resident #62's medication administration in response to the Consultant Pharmacist's Medication Regime Review for Resident #62 dated 2/16/23. She stated she did not recall the date of this observation. She further indicated Resident #62's MAR at the time of the observation reflected the most current physician's order the facility had in his record for buspirone 5 mg daily. She went on to say the buspirone dose available for Resident #62 at the time of her observation was 10 mg tablets. The DON stated she observed the staff member cut the 10 mg

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buspirone tablet in half and administer one half tablet equaling 5 mg to Resident #62. She went on to say she did not question why the pharmacy sent Resident #62 10 mg tablets of buspirone when the current physician's order was for one 5 mg tablet. She stated usually the form of the medication sent by the pharmacy would match the order. She further indicated she did not recall her thought process at the time. The DON stated normally if the pharmacy did not have the form of a medication ordered by the physician and needed to send a substitute there would be a label on the medication indicating this. She went on to say she did not recall this being the case for Resident #62 at that time. She further indicated the process when a physician sent an electronic prescription directly to the pharmacy was the pharmacy would then fax a copy of the prescription to the facility. The DON stated this fax usually went to the fax machine in the Nursing Supervisor's office. She went on to say the Nursing Supervisor would then put the order into the resident's medical record for display on the MAR because pharmacy did not have the capacity to do this. She stated she did not know why this had not occurred with the physician's order for Resident #62 to increase his buspirone dose to 10 mg daily dated 1/23/23. The DON went on to say the risk to Resident #62 from not receiving the ordered dose of his buspirone was experiencing increased anxiety. She stated she was not aware of any behaviors demonstrating increased anxiety by Resident #62 during that period.

On 8/24/23 at 10:55 AM an interview with the ADON indicated she would have entered the "buspirone 5 mg 2 tablets by mouth one time a day for anxiety (2 tablets equaled 10 mg new

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order dated 2/21/23)" immediately after she received it from the Nursing Supervisor. She stated the process for electronic prescriptions sent directly to the pharmacy was that the pharmacy would then fax a copy over to the facility and it would be entered in the resident's medical record. She further indicated this system was not fool proof. The ADON stated after she entered the order into Resident 62's medical record, she would have given it back to the Nursing Supervisor.

On 8/24/23 at 10:58 AM an interview with the Nursing Supervisor confirmed the facility process for electronic prescriptions sent directly to the pharmacy by a physician. She stated she did not know what happened to the New Prescription Summary for Resident #62 dated 1/23/23 for buspirone 10 mg take 1 tablet by mouth every morning for vascular dementia related anxiety. She confirmed it was not in Resident #62's medical record. She stated she did not recall ever receiving the fax from the pharmacy. The ADON went on to say there were 5 fax machines in the facility and the fax could have gone anywhere. She stated she probably got a physician's order for Resident #62 on 2/22/23 for "buspirone 5 mg 2 tablets by mouth one time a day for anxiety (2 tablets equaled 10 mg new order dated 2/21/23)" and gave it to the ADON to enter in Resident #62's medical record but she did not remember. She went on to say she could not find this either.

On 8/24/23 at 2:49 PM a telephone interview with Physician #1 indicated she did not really know what the facility process was for electronic prescriptions sent to the pharmacy. She stated she was familiar with Resident #62. She stated she did not think Resident #62 suffered any

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F 760	Continued From page 82 adverse consequences from not receiving the ordered dose of his buspirone. She stated she had not seen much change in Resident #62's behaviors in the 2 years she had been caring for him.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to a) ensure expired beverages were discarded and not available for use, b) ensure that frozen foods were sealed when stored to prevent freezer burn, c) ensure that foods were labeled, dated, stored, and left to thaw in a safe manner to prevent the potential for food borne illness. These practices had the potential to affect residents in the facility.	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary On 8/21/23, the Dietary Manager discarded all items in the Walk-in Refrigerator that were expired, not dated when opened or had a use by date when indicated to include but not limited to expired beverages (milk).	9/25/23

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Findings included.

During the initial tour of the kitchen on 08/21/23 at 10:45 AM the following was observed:

a. The walk-in refrigerator was observed with a crate of approximately 50 milk cartons, each with an expiration date of 08/19/23.

b. The walk-in freezer was observed with an opened box of fried chicken patties. The plastic bag that contained the patties was left open to air, and ice had formed on the patties.

c. The following food items: a container of ground turkey sausage unlabeled and with no date, a container of turkey sausage patties unlabeled, with no date, and a container of vegetable sausage patties unlabeled, with no date were left sitting out on a cart in the kitchen at room temperature.

During an interview on 08/21/23 at 10:45 AM Cook #1 stated the unlabeled containers of ground turkey sausage, and turkey sausage patties were served this morning for breakfast, and he left the containers sitting out until he could cook more sausage to add to them and serve for breakfast tomorrow. He stated the vegetable sausage patties were taken out of the freezer this morning around 10:00 AM and were left sitting out at room temperature to thaw. He indicated that he thought it was okay to leave food sitting out at room temperature for a period of time or to thaw. He stated the food would be discarded. He stated he forgot to label and date the food items. He indicated he had received training on food

On 8/21/23, the Dietary Manager discarded food items opened without an open date or use by date to include but not limited to opened packages of ground turkey/turkey patties, and vegetable sausage patties.

On 8/21/23, the Dietary Manager discarded all items in the Walk-in Freezer that were not dated when opened or had a use by date when indicated to include a box of fried chicken patties which was opened to air.

On 9/13/23, the Dietary Manager completed an audit of all items in the Walk in Freezer, Walk in Refrigerator and storage area to include items removed for cooking/thawing. This audit is to ensure there were no expired items, all items were labeled with an open date or an use by date when opened and that items were thawed per facility protocol. The Dietary Manager will address all concerns identified during the audit to include discarding all items not labeled/thawed per facility protocol.

On 8/21/23, the Dietary Manager initiated an in-service with all dietary staff regarding Monitoring Food Expiration Dates with emphasis on checking food items daily and removing expired items immediately from use with notification of the Dietary Manager.

On 8/25/23, the Dietary Manager initiated an in-service with the Dietary Manager

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F 812	Continued From page 84 storage. During an interview on 08/21/23 at 10:50 AM the Dietary Manager stated the Kitchen staff had received training on food storage, as well as labeling and dating foods. He stated the sausage patties, and ground sausage should not have been left out for that length of time and the frozen vegetable sausage should not have been sitting out at room temperature to thaw and should have been placed in the refrigerator to thaw. He stated those food items would be discarded. He stated the expired milk cartons should have been either removed from service or placed in an area in the refrigerator with a "Do not use" label. During a follow up interview on 08/24/23 at 1:00 PM the Dietary Manager stated he had worked at the facility for less than a year. He stated more training was needed for staff and in-services had started regarding proper food storage, labeling, and expiration dates, which were everyone's responsibility. He stated all expired foods should be removed from service and he expected foods to be stored properly and labeled and dated. During an interview on 08/25/23 at 5:00 PM the Administrator stated she was not aware of any concerns in the Kitchen. She indicated there had been no complaints from residents regarding the food. She stated the Kitchen staff were required to follow the procedures for safe food storage.	F 812	and dietary staff regarding to Labeling and Storage of Food Items When Opened with emphasis on labeling all food items in the Walk in Freezer, Walk in Refrigerator with an open date or an use by date when opened, sealing items after opening and process for thawing food items to ensure food service safety. In-services will be completed by 9/25/23. After 9/25/23, any dietary staff who has not completed the in-service will complete upon next scheduled work shift. All newly hired dietary staff will be in-serviced during orientation regarding Monitoring Food Expiration Dates and Labeling and Storage of Food Items When Opened The Dietary Manager will complete an audit of all items in the Walk in Freezer and Walk in Refrigerator to include items removed for cooking/thawing 3 times a week x 4 weeks then weekly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure there were no expired items, all items were labeled with an open date or an use by date when opened and that items were thawed per facility protocol. The Dietary Manager will address all concerns identified during the audit to include discarding items not labeled/stored or thawed per facility protocol and/or re-training of staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Kitchen Audit Tool to the Quality	

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F 812	Continued From page 85	F 812	Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Kitchen Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
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 will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		9/25/23

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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.

§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;

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F 867	Continued From page 87 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 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;	F 867		

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F 867	Continued From page 88 (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 interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint survey of 04/13/22. This was for a recited deficiency in the area of Advance Directives (F578). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F578: Based on record review and staff interviews the facility failed to ensure advanced directive information matched throughout the medical record for 1 of 1 resident (Resident #25) reviewed for advanced directives. During the recertification and complaint survey of 04/13/22, the facility was cited for failing to have an advance directive in the medical record for 1 of 1 resident reviewed for advanced directives (Resident #48). In an interview with the Administrator on 08/25/23 at 3:22 PM she stated she was not sure why the previous plan of correction didn ' t work but she would re-evaluate the process and correct the issue. She thought that perhaps they had not	F 867	F867 QAPI/QAA Improvement Activities On 9/8/23, The Facility Consultant initiated an audit of previous citations and action plans within the past year related to F578 Advance Directives to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 9/25/23. On 9/8/23, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON)/ Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include updated advance directives. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement	

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F 867	Continued From page 89 monitored the issue long enough or had failed to revisit it after the audits had been completed to ensure staff were continuing to document advance directives. The previous plan of correction included an Advance Directive Audit Tool that was completed on admission and re-admission of residents by the nursing staff and reviewed weekly by the Director of Nursing for 4 weeks then monthly for 1 month. The Administrator was responsible for taking the Audits to the Quality Performance Improvement Committee monthly for 2 months.	F 867	changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 9/25/23. All newly hired Administrator, DON and ADON/QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include advance directives, will be taken to the Quality Assurance committee for review monthly x 3 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if a plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include updated advance directives and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse	

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F 867	Continued From page 90	F 867	to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	