STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 09/01/2023

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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E 000	Initial Comments The survey team entered the facility on 8/28/2023 to conduct a recertification and compliant investigation survey. Due to the potential for adverse weather conditions and unsafe travel conditions related to a hurricane, the survey was conducted remotely on 8/13/2023. The survey team returned to the facility on 9/1/2023. Therefore, the exit date was 9/1/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #X5W011.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 8/28/2023 to conduct a recertification and compliant investigation survey. Due to the potential for adverse weather conditions and unsafe travel conditions related to a hurricane, the survey was conducted remotely on 8/13/2023. The survey team returned to the facility on 9/1/2023. Therefore, the exit date was 9/1/2023. Event ID #X5W011. The following intakes were investigated NC00193474, NC00194131, NC00194976, NC001197623, NC00197823, NC00198639, NC001199975, NC00201997, NC001202829, NC00206452 and NC00205599. 31 of the 31 complaint allegations did not result in deficiency.	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	F 578		9/28/23

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

Electronically Signed | 09/21/2023

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F 578	Continued From page 1	F 578		

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).
(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.

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F 578	Continued From page 2 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 #67) reviewed for advanced directives. Findings included: Resident #67 was admitted to the facility on 10/25/2021. Resident #67's electronic medical record revealed an active physician's order dated 12/13/22 that read DNR (Do Not Resuscitate). A review of Resident #67's paper medical chart revealed there was no advanced direction information in the paper medical chart. The facility did not have an additional notebook with resident DNRs at the nursing station. Resident #67's quarterly Minimum Data Set (MDS) assessment dated 7/17/23 revealed Resident #67 was cognitively intact. An interview was conducted on 9/1/23 at 8:38 A.M. with Resident #67. Resident #67 indicated she was unable to recall when, but she told someone at the facility she did not "want her chest pumped or someone to breathe for her if her body stopped working". She stated she was unable to remember what it was called or who asked her about her code preference. An interview was conducted on 8/30/23 at 12:11 P.M. with Nurse #1. During the interview, Nurse #1 stated she was unfamiliar with Resident #67's	F 578	Barbour Court 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 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. Barbour Court Nursing and Rehabilitation 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, Barbour Court 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 9/18/23, the Unit Manager reviewed and updated resident #67□s desire for advance directive and code status. The resident□s chart was updated with an order for desired code status, supporting documentation to include a golden rod was placed in the medical chart. On 9/18/23, the Medical Records Director	

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F 578	Continued From page 3 code status. Nurse #1 explained if something happened and Resident #67's code status was needed, she would look in Resident #67's paper medical chart at the nurse's station to determine if CPR (Cardiopulmonary Resuscitation) was required to be administered. Nurse #1 looked in Resident #67's paper medical chart and stated there was no DNR paperwork on file. Nurse #1 stated if Resident #67's code status was needed, she would check Resident #67's paper medical chart at the nurse's station and without seeing an advanced directive, she would have started CPR (cardiopulmonary resuscitation) on Resident #67. An interview was conducted on 8/30/23 at 12:14 P.M. with Unit Manager #1. The Unit Manager looked in Resident #67's paper medical chart at the nurse's station and stated Resident #67's DNR form was not in the medical chart. During the interview, the Unit Manager stated DNR forms were kept at the nurse's station in the resident's paper medical chart. Unit Manager #1 explained Resident #67 had signed a DNR form and the form was placed in Resident #67's paper medical chart. She stated Resident #67 may have had an outside medical appointment and the DNR form was not returned to Resident #67's paper medical chart when she returned from the appointment. The Unit Manager stated Resident #67 had several appointments and she was unable to determine when the DNR form was misplaced. An interview was conducted on 8/30/23 at 12:45 P.M. with the Director of Nursing (DON). During the interview, the DON stated Resident #67's DNR form should be in her paper medical chart located at the nurse's station. The DON stated she was unsure why Resident #67's DNR was not located in her paper medical chart and explained	F 578	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 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 9/28/23. On 9/18/23, 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.	

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F 578	Continued From page 4 the form may have been misplaced when Resident #67 had a medical appointment, and the form was removed to be transferred with her to the outside medical appointment. The DON further explained the assigned nurse when Resident #67 returned from her appointment was responsible to ensure the DNR was received and returned to Resident #67's paper medical chart. The DON was unsure when Resident #67's DNR form was misplaced, or which nurse was assigned Resident #67 when the form was misplaced.	F 578	On 9/18/23, the 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 9/28/23. After 9/28/23 any nurse who has 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 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	

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F 578	Continued From page 5	F 578	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 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 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,	F 645		9/28/23

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F 645	Continued From page 6 (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified,	F 645		

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F 645	Continued From page 7 before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident with a mental disorder had received a Preadmission Screening and Resident Review (PASRR) prior to admission to the facility for 1 of 4 residents reviewed for PASRR (Resident #100). Findings included: Resident #100 was admitted to the facility on 3/15/2023 from another nursing home with a diagnosis of bipolar disorder. Resident #100 was discharged to the hospital on 3/18/2023 and was readmitted on 4/10/2023. The admission Minimum Data Set (MDS) assessment dated 4/16/2023 indicated Resident #100 was not considered by the state Level II PASRR process to have a serious mental illness. There were no Level II PASRR conditions marked for serious mental illness. The MDS indicated Resident #100's diagnoses included bipolar disorder. Resident #100 was noted as receiving	F 645	F 645 PASARR Screening for MD & ID On 3/9/2023, a PASRR screening was completed by the referring facility for resident #100 and returned as Level II effective 3/15/23. On 9/1/23, the MDS Nurse updated resident medical record to reflect Level II PASRR. On 9/18/2023, the Minimum Data Set Nurse (MDS) and the Medical Records Director initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation. The Social Worker and/or Admission Director will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation. The audit will be completed by 9/28/23.	

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F 645	Continued From page 8 an antipsychotic (treatment for mental health conditions) medication daily. Resident #100's care plan dated 4/22/2023 included a focus for the use of psychotropic drugs for diagnosis of bipolar disorder, and interventions included evaluating the effectiveness and side effects of psychotropic medications. The care plan did not include PASRR information. A psychiatric evaluation progress note dated 5/9/2023 recorded Resident #100 with a long history of bipolar disorder and treatment included administration of lurasidone, an antipsychotic medication used to treat mental health conditions like bipolar disorder. Physician orders dated 7/25/2023 included lurasidone hydrochloride 20 milligram tablet at bedtime for bipolar disorder. On 8/29/2023 at 2:33 p.m. the Administration provided a copy of Resident #100's PASRR Level II determination notification letter dated 3/15/2023. Resident #100's physical and mental needs had been evaluated and deemed nursing facility placement was appropriate for Resident #100. There was no end date or limitation unless Resident #100 had a change in her condition. On 9/1/2023 at 11:00 a.m. during an interview with the Admission Coordinator, she reviewed emails and information received from the transferring facility and stated they did not share any information indicating a new diagnosis for Resident #100 or submission of a Level II PASRR screening prior to her admission. She explained she ensured new admissions had a Level I	F 645	On 9/18/23, the Admission Coordinator initiated an audit of all newly admitted residents, readmitted residents or residents transferring from another facility to ensure residents were screened for a PASRR level per facility protocol. The Social Worker will address all concerns identified during the audit to include submitting a PASRR through the North Carolina Medicaid Uniform Screening tool and updated resident medical record when indicated. The Audit will be completed by 9/28/23. On 9/18/23, the Administrator initiated an in-service on Level II PASRRs with the Admission Director, Social Workers, Minimum Data Set Nurse (MDS), Director of Nursing and administrative nurses with emphasis on referral for evaluation/re-evaluation of PASRR on admission to include transfer from another facility, following changes in mental health status or new Level II qualifying diagnosis. All newly hired Admission Director, Social Worker, Minimum Data Set Nurse (MDS), administrative nurses and Director of Nursing will be in-service during orientation on PASRRs with emphasis on PASRR screening on admission to include transfer from another facility and/or with changes in mental health status or new Level II qualifying diagnoses. In-service will be completed by 9/28/23. All newly hired Admission Director, Social Workers, Minimum Data Set Nurse (MDS), Director of Nursing will be in-serviced during orientation regarding Level II PASRRs.	

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F 645	Continued From page 9 PASRR, and Level II PASRR screenings were submitted by the Social Workers. On 9/1/2023 at 8:47 a.m. in an interview with MDS Nurse #1, she stated according to Resident#100's FL2 (Medicaid form) information, she had a Level I PASRR determination. She explained she had not received any information that Resident #100 had a Level II PASRR determination. On 9/1/2023 at 9:54 a.m. in an interview with Social Worker #1, she explained she was the assigned social worker for Resident #100 and did not have a Level II PASRR determination for Resident #100. She stated Resident #100 was admitted from another nursing home with a Level I PASRR noted on the FL2 form. Therefore, she did not think Resident #100 needed a Level II PASRR evaluation submitted for her diagnosis of bipolar disorder. She stated this was the first time she was seeing the Level II PASRR Determination Notification letter provided to the surveyor by the Administration on 8/29/2023. In a follow up interview with Social Worker #1 on 9/1/2023 at 11:04 a.m., she stated she was new to the position, and they were responsible for submitting Level II PASRR information for determination. She explained since Resident #100 had a diagnosis of bipolar disorder, she thought the transferring facility had completed the Level II PASRR screening process, and the Level I PASRR was current. She stated she should have checked the North Carolina Medicaid Uniform Screening Tool (NC MUST) system to confirm Resident #100 had been screened for a Level II PASRR determination. On 9/1/2023 at 10:51 p.m. in an interview with	F 645	The MDS nurse and/or Unit Managers will review all newly written orders for psychotropic medications and/or mental health diagnoses to include resident #100 weekly x 4 weeks then monthly x 1 month utilizing the Orders Listing Report. This audit is to ensure any newly written PASRR qualifying diagnosis and/or medications is reviewed to determine the need for re-submission of PASRR information. The Unit Manager, Social Worker and/or MDS nurse will address all concerns identified during the audit to include completing a new PASRR review. The Director of Nursing (DON) will review the Orders Listing Report weekly for 4 weeks then monthly for 1 month for completion and ensure all areas of concern were addressed. The MDS nurse and/or Unit Managers will audit all newly admitted residents to include residents admitted from another facility to ensure residents were screened for a PASRR level per facility protocol. The Social Worker will address all concerns identified during the audit to include submitting a PASRR through the North Carolina Medicaid Uniform Screening tool, updating resident medical record when indicated and/or re-training of staff. The Assistant Administrator will review the PASRR Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Orders Listing Report and the PASRR Audit Tool to the Quality	

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F 645	Continued From page 10 Social Worker #2, he stated based on the NC MUST report, the transferring facility submitted Level II PASRR information for Resident #100 on 3/9/2023 due to a change in condition. The report noted the Level II PASRR screening was completed and listed the start date as 3/15/2023. He explained the PASRR information printed on 8/29/2023 was different from information received from the transferring facility for Resident #100. He stated Resident #100's FL2 form recorded a Level I PASRR with a diagnosis of bipolar disorder on admission and a Level II PASRR evaluation should have been submitted. On 9/1/2023 at 10:00 a.m. in an interview with the Administrator, he explained the new Level II PASRR Determination Notification letter for Resident #100 was printed from the NC MUST program on 8/29/2023 by Social Worker #2. He explained it was after the PASRR information was requested they became aware of Resident #100's Level II PASRR status. He explained the transferring facility only provided Level I PASRR information for Resident #100. They thought since Resident #100 was being admitted from another nursing home she had been screened for Level II PASRR by the other facility and remained a Level I PASRR. He stated Resident #100 had arrived on 3/15/2023 at 1:00 p.m. and he understood the transferring facility received the Level II PASRR information at 3 p.m. on 3/15/2023 but did not call or email the facility to share the information. He said the facility was not aware of the Level II PASRR for Resident #100 until 8/29/2023. In a follow up interview on 9/1/2023 at 11:10 a.m., the Administrator stated residents' diagnoses warranting Level II PASRR screening were discussed in the interdisciplinary morning	F 645	Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Orders Listing Rep Orders Listing Report and the PASRR 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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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

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F 645	Continued From page 11 meetings. He explained if Resident #100 had transferred in from the hospital initially, her diagnosis of bipolar disorder would have triggered a Level II PASRR screening, but because she transferred from another nursing home facility, a Level II PASRR was not triggered for initiation. He stated the transferring nursing home failed to share the information about Resident #100's Level II PASRR Screening results with them and this facility did not verify Resident #100's Level II PASRR status in the NC MUST program.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		9/28/23

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F 655	Continued From page 12 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an individualized person-centered baseline care plan that included the use of an indwelling urinary catheter for elimination for 1 of 2 residents reviewed for urinary catheters (Resident #240). Findings included: Resident #240 was admitted to the facility on 2/2/2023 and diagnoses included fracture right femur. The nursing admission assessment dated 2/2/2023 at 10:37 p.m. recorded Resident #240's indwelling urinary catheter was draining clear yellow urine. Physician orders dated 2/2/2023 included	F 655	F655 Baseline Care Plan Resident #240 no longer resides in the facility. On 9/18/23, the Unit Manager initiated an audit of all admissions and/or readmissions for the past 30 days. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident to include but not limited to use of indwelling catheters that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the	

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F 655	Continued From page 13 providing urinary catheter care with soap and water every shift. Physician progress notes dated 2/3/2023 recorded use of the indwelling urinary catheter was due to Resident #240's inability to sit up and use a urinal after surgery of to the right femur. The baseline care plan dated 2/3/2023 for Resident #240 did not address the use of an indwelling catheter for urine elimination. On 9/01/2023 at 9:30 a.m. in an interview with Nurse #2, he stated the unit manager or assigned admission nurse on evenings and weekends started residents' electronic baseline care plans within forty-eight hours of admission. In a follow up interview on 9/1/2023 at 12:53 p.m., Nurse #2 explained Resident #240 was admitted to the facility late in the evening of 2/2/2023 and admission assessments were completed the following morning on 2/3/2023. He stated baseline care plans were based on items triggered on the admission assessment, and the indwelling urinary catheter should had been addressed on Resident #240's baseline care plan. Nurse #2 stated unit managers were responsible for checking the admission checklist which included the baseline care plan for completion of all items and stated asthe unit manager, he "dropped the ball" with Resident #240's baseline care plan. On 9/01/2023 at 12:00 p.m. during an interview with the Director of Nursing, she stated after Resident #240's admission process was completed, the unit manager was to check that the baseline care was started within forty-eight hours and included the use of the indwelling	F 655	care plan. All areas of concern were immediately addressed by the MDS nurse and Unit Managers. Audit will be completed by 9/28/23. On 9/18/23, the Staff Development Coordinator initiated an in-service with all nurses, Minimum Data Set (MDS) Coordinator, and MDS nurse regarding Baseline Care Plans. Emphasis includes guidelines to develop and implement a baseline care plan for each new admission and/or readmission within 48hrs that includes instructions needed to provide effective and person-centered care of the resident to include but not limited to use of indwelling catheter, minimum healthcare information necessary to properly care for a resident, and that the facility must provide the resident and their resident representative with a summary of the baseline care plan. In-service will be completed by 9/28/23. After 9/28/23, any nurse who has not worked or completed the in-service will complete it prior to next scheduled work shift. All newly hired will be in-serviced regarding Baseline Care Plans during orientation. 10% audit of all admissions and/or readmissions will be completed by the Assistant Director of Nursing (ADON) and/or Minimum Data Set Nurse (MDS) utilizing the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48	

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F 655	Continued From page 14 urinary catheter.	F 655	hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident to include but not limited to indwelling catheters that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concern will be immediately addressed by the ADON or MDS nurse to include retraining of staff as indicated. The Director of Nursing (DON) will review and initial the Baseline Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns have been addressed. The Director of Nursing will forward the results of Baseline Care Plan Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Baseline Care Plan 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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		9/28/23

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F 761	Continued From page 15 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to discard a resident's unlabeled opened Humalog insulin vial from 1 of 3 medication storage rooms observed (Specialized Programming for Alzheimer's Related Care [SPARC] unit). Findings included: Resident #119 was admitted to the facility on 6/15/2022. Physician orders dated 7/25/2023 included an order for Humalog solution 100unit/ml (Insulin Lispro (Human) inject as per sliding scale subcutaneously before meals for diabetes mellitus: if 0-150=0 units, 151-200= 2 units, 251-250=4 units, 251-300=6 units, 301-350=8 units, 351-400 =10 units; 401+ =12 units or	F 761	F761 Label/Store Drugs and Biologicals On 8/30/23, the Unit Manager removed and discarded the vial of Humalog insulin not labeled with an open/expired date from the medication storage room for resident #119. The mediation was discontinued on 7/31/23 and was not reordered. On 9/18/23, the Unit Managers initiated an audit of all medication carts and medication storage rooms to include the medication storage room on Specialized Programming for Alzheimer's Related Care (SPARC) unit. The audit is to ensure medication is labeled with an open date or use by date when opened if indicated and no medications were noted to be expired.	

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F 761	Continued From page 16 above. Call MD if patient symptomatic. The order stated to discard the medication 28 days after opening and to check the expiration date. The order for Humalog insulin was started on 7/25/23 and was discontinued on 7/31/23. A review of Resident #119's Medication Administration Record for July 2023 indicated blood glucose monitoring was conducted three times a day and blood glucose levels were recorded less than 150 requiring no Humalog insulin administration to Resident #119. On 8/30/2023 at 11:40 a.m. during observation of the medication storage area for the SPARC unit with Nurse #2, a vial of Resident #119's Humalog insulin was observed open in a medication bottle with no vial cap located on top of the vial in the medication storage area refrigerator. The manufacture's expiration date on the vial of Humalog insulin read 3/13/2026. A label on the Humalog insulin vial read to discard in twenty-eight days, and there was no open date indicated on the label. The label on the outside of the medication bottle indicated the vial of Humalog Insulin was dispensed from the pharmacy on 7/27/2023. On 8/30/2023 at 11:40 a.m. in an interview with Nurse #2, she stated she was unsure when Resident #119's vial of Humalog insulin was opened and based on the date the pharmacy dispensed the medication (7/27/2023), the vial of Humalog insulin was expired and discarded the vial of Humalog insulin into the sharp's container on the SPARC's medication cart. She said Resident #119 had not received any of the Humalog insulin and explained refrigerated medications in the SPARC unit medication storge	F 761	All identified areas of concern were addressed by the Unit Managers during the audit to include dating items when indicated and/or removal of expired medication. Audit will be completed by 9/28/23. On 9/18/23, the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding to Medication Storage with emphasis on (1) checking medications before administration for expired dates (2) appropriately discarding expired medications per pharmacy policy, and (3) labeling medications with an open date or use by date when indicated. In-service will be completed by 9/28/23. After 9/28/23, any nurse or medication aide who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses and medication aides will be in-service during orientation regarding Medication Storage. The Assistant Director (ADON) of Nursing and/or Staff Development Coordinator will audit all medication carts and medication storage rooms to include the medication storage room on SPARC unit weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. The audit is to ensure medication is labeled with an open date or use by date when opened if indicated and no medications were noted to be expired. All identified areas of concern will addressed by the ADON and/or Staff Development Coordinator during the audit to include dating items	

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F 761	Continued From page 17 area were checked weekly for expiration date. In a follow up phone interview with Nurse #2 on 9/1/2023 at 1:15 p.m., she stated on 8/30/2023 she was assigned to the SPARC unit medication cart and had not had a chance to check the medication refrigerator on the SPARC unit for expired medications. On 8/30/2023 at 11:42 a.m. in an interview with the Director of Nursing (DON), she explained Resident #119's vial of Humalog insulin should have been discarded when the physician's order was written on 7/31/2023 to discontinue Resident #119's order for Humalog insulin and stated medications in the medication storage areas were to be checked daily for expired medications. In a follow up interview with the DON on 9/1/2023 at 11:57 a.m., she explained there was no reason for Resident #119's vial of Humalog insulin to be opened because Resident #119 had not required the use of Humalog insulin since ordered. She stated they were unable to determine when and why the cap was removed from Resident #119's vial of Humalog insulin and open vials of Humalog insulin expired in twenty-eight days after opening.	F 761	when indicated, removal of expired medication and re-training of staff. The Director of Nursing (DON) will review the Medication Audit Tool weekly x 4 weeks then monthly x 1 month. The Director of Nursing will forward the results of Medication Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Medication 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 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		9/28/23

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F 806	Continued From page 18 different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interivew and staff interviews, the facility failed to honor food preferences for 1 of 2 residents reviewed for food preferences (Resident #100). Findings included: Resident #100 was admitted to the facility on 03/15/2023. Resident #100's care plan dated 4/25/2023 included a focus for nutrition with actual weight loss due to cardiac disease. Interventions included providing diet as ordered and referencing dietician evaluations and recommendations. Physician orders dated 5/2/2023 included an order for a regular texture no added salt diet and to encourage fluids and offered hydration periodically every day for hydration. The quarterly Minimum Data Set (MDS) assessment dated 7/03/2023 indicated Resident #100 was moderately cognitively impaired and independently fed herself after the meal tray was set up. Dietary documentation dated 7/18/2023 indicated Resident #100 was receiving a regular textured no added salt diet with thin liquids and was consuming 50-100% on her dietary meals. The dietary note warranted no nutrition concerns although Resident #100 had experienced a 11.3% weight loss in last 90 days because Resident #100's weight had stabilized in the last 30 days.	F 806	F806 Resident Allergies, Preferences, Substitutes On 9/19/23, the Dietary Supervisor updated resident #100 food preferences. On 9/19/23, the Assistant Administrator observed meal delivery to resident #1 for all three meals to ensure the resident was provided food preferences as requested. There were no additional concerns identified. On 9/19/23, the Dietary Supervisor initiated food preference audit with all residents able to report. The Dietary Supervisor will update food preferences in the electronic record. The audit will be completed by 9/28/23. On 9/19/23, the Assistant Administrator initiated an audit of meal delivery for lunch to ensure meal tray was accurate for meal delivery ticket to include resident preferences and/or that staff notified the dietary staff to obtain food per meal delivery ticket/resident food preference. The Dietary Supervisor will address all concerns identified during the audit to include obtaining food per meal delivery ticket/resident preference and education of staff. The audit will be completed by 9/28/23. On 9/19/23, the Assistant Administrator initiated an in-service with all dietary staff	

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F 806	Continued From page 19 There were no recommendations for dietary changes. On 8/30/2023 at 12:45 p.m., Resident #100 was observed sitting up in wheelchair eating lunch. Resident #100's meal ticket read regular diet, eight-ounce water, two eight-ounce teas and wants some kind of fruit every meal. There was no eight-ounce water and no fruit observed on the meal tray. There was only one eight-ounce tea observed on the meal tray. Resident #100 stated she had her own water pointing to her water container and requested two teas for her meal trays. She explained she usually only received one tea and stated instead of receiving fruit on the lunch tray, she received a cookie. On 8/30/2023 at 1:17 p.m. in an interview with Dietary Aide #1, she stated she was responsible for informing the dietary staff on the lunch serving line of the preferences listed on Resident #100's meal ticket. She explained she forgot and did not call out to the dietary staff for Resident #100 to get two glasses of tea and fruit for the lunch meal tray. O 8/30/2023 at 1:13 p.m. in an interview with Dietary Supervisor, she stated residents should receive requested items on the meal tickets unless the food items are not available and stated fruit and teas were available for lunch meal trays. She explained dietary staff on the serving line were informed fruit for the lunch tray was bananas, and there were plenty of teas to provide Resident #100 two teas because there were cups of tea left at the completion of the lunch meal trays. She said Resident #100 not receiving tea eight-ounce teas and fruit on the meal tray as indicated on the meal ticket was an error on the	F 806	regarding Resident Meals with emphasis on ensuring meal tray is accurate for current diet order and/or resident food preferences prior to placing on tray delivery system. The in-service will be completed by 9/28/23. After 9/28/23, any dietary staff who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Resident Meals. On 9/19/23, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident Meals with emphasis on checking meal delivery ticket for accuracy of tray to include resident food preferences and immediately notifying the dietary staff of any inconsistencies and/or to obtain appropriate meal tray/food preferences. The in-service will be completed by 9/28/23. After 9/28/23, any dietary staff who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Resident Meals. The Assistant Administrator and/or Unit Managers will complete meal observations 5 times a week x 4 weeks then weekly x 1 month to include all meals to ensure meal tray was accurate for meal delivery ticket to include resident preferences and/or that staff notified the dietary staff to obtain food per meal delivery ticket/resident food preference. The Dietary Supervisor will address all	

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F 806	Continued From page 20 serving line. She explained there was new dietary staff members on the serving line, and she would re-educate the dietary staff on granting resident's preferences and checking resident meal trays against the meal ticket for accuracy. On 9/01/2023 at 11:17 a.m. in an interview with the Administrator, he stated Resident #100 should had received items listed as preferences on the meal ticket on the lunch meal tray. He stated he had not received any dietary concerns from Resident #100's family or the Resident Council with the dietary department not honoring resident preferences.	F 806	concerns identified during the audit to include obtaining food per meal delivery ticket/resident preference and education of staff. The Administrator will review the Meal Observation Audit 5 times a week x 4 weeks then weekly x 1 month to ensure all concerns are addressed. The Administrator will forward the results of Meal Observation Audit to the Quality Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Meal Observation Audit 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 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.	F 867		9/28/23

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F 867	Continued From page 21 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and 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	F 867		

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	345237	A. BUILDING _____ B. WING _____	C 09/01/2023

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F 867	Continued From page 22	F 867		

safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

§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.

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F 867	Continued From page 23 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, 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 4/8/2022. This was for two recited deficiencies on the current recertification and complaint investigation survey of 9/01/23. The deficiencies included Baseline Care Plan (F655) and Resident Allergies, Preferences and Substitutes (F806). 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: F-655 Based on record review and staff interviews, the facility failed to develop and implement an	F 867	F867 QAPI/QAA Improvement Activities On 9/19/23, the Facility Consultant initiated an audit of previous citations and action plans from 4/2022 to present related to F655 Baseline Care Plans and F806 Allergies/Preferences 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 Administrator 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 9/28/23. On 9/19/23, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Unit Managers regarding the Quality Assurance (QA) process to include	

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F 867	Continued From page 24 individualized person-centered baseline care plan that included the use of an indwelling urinary catheter for elimination for 1 of 2 residents reviewed for urinary catheters (Resident #240). During the recertification and complaint survey of 4/8/2022, the facility was cited for failure to complete a baseline care plan within 48 hours for a newly admitted resident. In an interview with the Administrator on 9/1/2023 at 1:13 p.m., he stated baseline care plans were added to the admission checklist for unit managers to ensure baseline care plans were started on new admissions. He explained the admission checklist was sent to Quality Assurance Performance of Improvement (QAPI) to review for completion of tasks on the admission checklist. He stated all nurses were trained on how to initiate a baseline care plan, and care plans were reviewed in interdisciplinary (IDT) meetings. He reported since November 2022, there had been no issues identified with the initiation of a baseline care plan for new admissions. F-806 Based on record review, observations, resident interview and staff interviews, the facility failed to honor food preferences for 1 of 2 residents reviewed for food preferences (Resident #100). During the recertification and complaint survey of 4/8/2022, the facility was cited for failure to provide resident's food preferences as listed on the meal tray ticket for a resident. In an interview with the Administrator on 9/1/2023	F 867	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 changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 9/28/23. All newly hired Administrator, DON and 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 baseline care plans, resident	

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F 867	Continued From page 25 at 1:13p.m., he stated there had been no concerns identified with residents not receiving their dietary preferences in Quality Assurance Performance of Improvement (QAPI) meetings. He explained due to the Dietary Manager being out of work for medical reasons and employment of some new staff members in the dietary department, he had assigned the Assistant Administrator to oversee the operations of the dietary department.	F 867	allergies/preferences and all current citations and that the QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and Unit Managers for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Director of Nursing to the 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.	