STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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E 000	Initial Comments An unannounced recertification survey was conducted on 09/11/23 through 09/14/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6PNX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 09/11/23 through 09/14/23. Event ID# 6PNX11. The following intakes were investigated NC00206681, NC00205911 and NC00205563 . 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		10/5/23

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

Electronically Signed | 10/05/2023

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F 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to invite the resident or resident responsible party to participate in the care planning process for 1 of 18 residents whose care plans were reviewed (Resident #27). Findings included: Resident #27 was originally admitted on 4/14/23 and readmitted on 7/6/23. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/12/23 revealed Resident #27 had been assessed as cognitively intact. Review of Resident #27's care plan revealed it had been reviewed and revised on 7/14/23, but there was no indication that the resident or a resident representative had participated in the care plan meeting or in development of the care plan. During an interview on 9/12/23 at 8:41 AM,	F 553	F-553 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #27 was invited by the Social Worker and attended is care plan meeting on 9/26/2023. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 9/21/2023 an audit was completed for the current quarter (July-September) by the Administrator to determine if any other residents and (or) their responsible party was not invited to participate in the care planning process. Audit revealed that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in	

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F 553	Continued From page 2 Resident #27 stated he had not been invited to attend a care plan meeting and did not recall participating in developing his plan of care since his initial admission into the facility. During an interview on 9/12/23 at 3:15 PM, the MDS Nurse stated the social worker usually printed out a monthly list of residents who were due for care planning and review and would send out invitations for scheduling the care plan meeting. During an interview on 9/12/23 at 3:50 PM, the Social Worker (SW) indicated she was responsible for invitations to the care plan meeting. She stated a monthly list of all residents whose care plans were due for review was printed. Letters were sent and phone calls made to schedule meetings with families. The SW stated Resident #27's last care plan meeting had been on 5/2/23. The SW stated they had missed the care plan meeting for Resident #27 in July 2023 when the care plan was revised. During an interview on 6/21/23 at 1:15 PM, the Director of Nursing (DON) stated care plan meetings were completed with residents and family members every 3 months or when there was change in the resident's condition and care plans were reviewed at that time. The DON explained the Social Worker was trying to ensure that all residents had care plan meetings conducted on time. During an interview on 9 /14/23 at 10:22 AM, the Administrator stated residents and/or resident representatives should be involved in the care plan meeting and make decisions about their care. The Administrator indicated documentation	F 553	the future: On 9/21/2023 the Administrator re-educated the Social Worker regarding the requirement that all residents and (or) the residents' responsible party are to be invited to participate in the care planning process. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that by reviewing the minimum data set care plan schedule, all residents and (or) their responsible party were invited to participate in the care planning process. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	

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F 553	Continued From page 3 related to the care plan attendance and meeting should be completed in a timely manner.	F 553		
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). (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.	F 578		10/5/23

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F 578	Continued From page 4 (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 records review, and staff interviews, the facility failed to have Advance Directives (code status) in the residents' records for 1 of 1 resident reviewed for Advance Directives (Resident #3). Findings included: Resident #3 was admitted to the facility on 8/2/23. The admission Minimum Data Set (MDS) dated 8/8/23 revealed Resident #3 was cognitively intact. Resident #3's care plan dated 8/14/23 did not contain information regarding code status or Advance Directives. At the time of review on 9/13/23, there was no active order for code status in Resident #3's medical record in neither the electronic health record (EHR) nor hard copy chart. An interview was conducted with Nurse #1 on 9/13/23 at 9:42 AM. Nurse #1 stated she would look in the EHR for a resident's code status. The code status was usually displayed next to the resident's picture or would be in the physician's orders. Nurse #1 reviewed Resident #3's electronic medical record and stated the resident did not have a code status. Nurse #1 explained if	F 578	F-578 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #3's advance directive (code status) was placed in the medical record on 9/14/2023 by the Director of Nursing (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 9/29/2023 an audit was completed by the Director of Nursing to ensure that all residents had an Advanced Directive (code status) in their medical record. Audit revealed that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 9/21/2023 the Administrator re-educated the Social Worker regarding the requirement that all residents are to have an Advance Directive (code status) in their medical record. (4) Indicate how the facility plans to	

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F 578	Continued From page 5 there was no code status in the EHR, she would refer to the resident's hardcopy chart for Advance Directives. Nurse #1 reviewed the resident's hard copy chart and there was no information in the Advance Directive tab. During an interview on 9/13/23 at 10:00 AM, the Director of Nursing (DON) stated the residents Advance Directives were entered by the admission nurse upon admission. Nurses looked for a resident's code status under the resident profile or displayed next to the resident's picture in the EHR. Nurses could also looked up in the physician orders or in resident's hard copy chart. The DON reviewed Resident #3's EHR and hard copy chart and there was no information regarding the resident's code status. The DON then reviewed the resident's hospital discharge summary dated 8/2/23 and indicated the resident was "Full Code." During an interview on 9/13/23 at 11:52 AM, the facility's Medical Director stated that the admission staff would speak with the resident or resident representative about Advance Directives and code status at the time of the admission. This information was relayed to the admission nurse and the code status was entered in the orders. The Medical Director would review the information and would sign it. The Medical Director explained this information should be available in the residents' medical records. The Medical Director further explained the code status of any resident should not be dependent on their hospital discharge summary but should be their wishes at the time of admission. During a follow-up interview on 9/13/23 at 12:45 PM, the DON stated a "Full Code" Agreement	F 578	monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that by reviewing on admission with the clinical team that the Advance Directive (code status) is listed and in the medical record along with care plan meeting review to ensure that any changes in the Advance Directive (code status) were updated and in the medical record. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	

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F 578	Continued From page 6 was signed by the resident's legal guardian at the time of admission. This information was not transcribed into resident's medical records by the admitting nurse. During an interview with the Administrator on 9/14/23 at 9:58 AM, he stated nurses usually enter a resident's code status order into a resident's chart. Advance directives should be addressed upon admission and entered in the resident's chart. Resident #3 should have a code status order and care plan in his medical record.	F 578		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on the Casper Payroll Based Journal (PBJ) for fiscal year Quarter 2 2023 (January 1 - March 31) report, record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 8 of 31 days reviewed. (3/4/23, 3/5/23, 3/10/23, 3/11/23, 3/12/23, 3/17/23,	F 727	F-727 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected.	10/5/23

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F 727	Continued From page 7 3/18/23, and 3/19/23). Findings included: Review of the Casper PBJ staffing data report for fiscal year Quarter 2 2023 (January 1 - March 31) revealed there were no RNs on 3/11/23, 3/12/23, 3/18/23 and 3/19/23. Review of the facility's Calculated Time of Entry - PBJ RN report and daily staffing report revealed the following: On 3/4/23 there was one (1) RN who worked only 6.5 hours. The facility census was 94. On 3/5/23 there was one (1) RN who worked only 5 hours. The facility census was 94. On 3/10/23 there was no RN available. The facility census was 94. ON 3/11/23 and 3/12/23 there were no RNs available. The facility census on both these days was 95. On 3/17/23 there was one (1) RN who worked only 1.5 hours. The facility census was 92. On 3/18/23 and 3/19/23 there were no RNs available. The facility census on both these days was 94. During an interview on 9/12/23 at 2:02 PM, the Scheduler stated she had included the Minimum Data Set (MDS) Nurse who was a RN as an RN on the schedule. On occasion she had included the Assistant Director of Nursing (ADON) as the RN on the schedule. She confirmed both staff members were not assigned to the medication cart or were assigned residents under their care. The scheduler stated she was informed that the MDS nurse or any RN in the building could be included in the daily staffing sheet. She was not aware that the staff should be assigned to the	F 727	(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 9/22/2023 the Administrator re-educated the Director of Nursing and the scheduler regarding the daily Registered Nurse staffing requirements that require at least 8 hours of RN coverage per day, 7 days a week and is to also have specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care. RN staff that do not meet the above criteria will not be counted. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that through reviewing the daily staffing schedule in advance with the Director of Nursing and the Scheduler, the required daily Registered Nurse staffing requirements are met. This monitoring	

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F 727	Continued From page 8 cart or assigned to residents' care. During an interview on 9/12/23 at 2:18 PM, the Director of Nursing (DON) stated he overlooked the daily staffing schedule to ensure the staff were properly scheduled for the day. There was no difference in the number of staff scheduled for weekdays or weekends. Staffing was based on census and acuity of the resident. The scheduler was in constant contact with the DON related to staffing. He stated he does not review the PBJ report to ensure there was RN working 8 consecutive hours a day for 7 days. The DON stated he was not assigned to work on the medication cart. During an interview on 9/14/23 at 1:53 PM, the Administrator stated a PIP was started on 8/15/23 for RN coverage for 8 hours/day. He further stated that this had stemmed from the PBJ report that was submitted to the Center for Medicare and Medicaid Services (CMS). The Administrator indicated that the corporate office submitted the PBJ report to CMS. This was identified during a meeting with the Corporate. The plan of corrections included auditing the current quarter to ensure that the PBJ requirement of at least 8 consecutive hours of RN coverage, educating the DON of the CMS requirement and the scheduler to attend daily Morning meetings and review reports of RN availability. The Administrator indicated the staffing schedule was reviewed a week in advance by himself, the scheduler, and the DON. Changes were made as needed. The Administrator indicated that he had completed the PBJ audits starting 7/1/23 to ensure there was RN coverage available for 8 consecutive hours. He further indicated daily audits were completed to ensure there was RN coverage at the facility	F 727	process will take place daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	

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F 727	Continued From page 9	F 727		

for at least 8 hours/day. The administrator stated he did not do any root cause analysis as he saw this as an opportunity to improve based on CMS requirement for 8 hours RN coverage. The Administrator indicated it appeared to be an oversight from the scheduler. He further indicated the scheduler was not educated on RN coverage and not educated to not include RN staff that were not assigned to the residents on the daily staffing sheets.

Review of the facility Quality Assurance and Performance Improvement (QAPI) Performance improvement Plan (PIP) revealed the opportunity to improve missing 8-hour RN coverage for PBJ requirement was identified. The measures put in place to ensure that the identified issues do not recur were 1) The Administrator audited the current quarter to ensure that PBJ requirements were met. This was completed on 8/15/23. 2) The DON was re- educated on the requirement on 8/15/23 by Administrator and Corporate Clinical Nurse. 3) The scheduler would attend morning meetings and review daily with the Administrator to ensure the PBJ requirements were met. Plan of Monitoring included daily monitoring by Administrator or DON to ensure at least 8 hours of consecutive RN coverage per day. The monitoring would take place throughout the remainder of 2023. Results would be discussed in the monthly Quality Assurance (QA) meeting and modified as needed.

A validation of the PIP was done on 9/14/23. In the PIP there was no information on how the issue of 8 hours of RN coverage was identified. There was no date indicating when this was identified. Review of the systemic changes revealed on 8/15/23 the Administrator audited the

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F 727	Continued From page 10 current quarter to ensure that PBJ requirements for 8 hours of RN coverage were met. This was completed on 8/15/23. The PIP included the audits from 7/1/23 to 9/13/23. Review of the in-service sign in sheet dated 8/15/23 revealed the DON had attended the in-service on PBJ RN hours which was facilitated by the Administrator and Corporate staff. There was no information on what was discussed during the monthly QA meeting regarding RN coverage. There was no information regarding any education or in-service provided to the scheduler. There was no correction date indicated on the PIP. The scheduler was interviewed on 9/12/23 at 2:02 PM. She indicated she did not receive any training or in-service. The scheduler stated she does attend the morning meeting. However, she does not check the PBJ report to ensure that there was RN working for 8 hours. During an interview with the DON on 9/14/23 at 4:00 PM, he indicated he was educated on the CMS regulation of RN coverage for 8 hours/day by the Administrator. The Administrator stated he was hired in February 2023.	F 727		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		10/5/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 11 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on the daily staffing sheets, actual working assignment sheets and staff interview, the facility failed to post accurate daily nurse staffing information for 8 out of 62 days for March 2023 and August 2023 reviewed for staffing. Findings included: A review of the nursing staff postings (report of nursing staff directly responsible for resident care) for March 2023 and August 2023 was conducted. The staff posting included the day	F 732	F-732 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be	

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F 732	Continued From page 12 shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility), a column for actual hours worked and a column for total hours. A review of the actual working assignment sheets compared to the daily staff posting sheets from 3/1/23 through 3/31/23 revealed the staff posting sheets were noted to have discrepancies of actual working hours and actual nursing staff that was physically in the facility working as RNs for 4 days of the 31 days reviewed for March 2023. " On 3/4/23 based on the facility's PBJ report the RN coverage was 6.5 hours. The daily staffing sheet indicated 8 hours of RN coverage. " On 3/5/23 based on the PBJ report, the RN coverage was 5 hours. The daily staffing sheet indicated 8 hours of RN coverage. " On 3/10/23 based on the PBJ report there was no RN coverage. The daily staffing sheet indicated 3 RNs staff working 24 hours. " On 3/17/23 per PBJ report, there was RN coverage for only 1.5 hours. The daily staffing sheet indicated 3 RNs working 24 hours. A review of the actual working assignment sheets compared to the daily staff posting sheets from 8/1/23 through 8/31/23 revealed the staff posting sheets were noted to have discrepancies of actual working hours and actual nursing staff that was physically in the facility working as RNs for 4 days of the 31 days reviewed for August 2023. During an interview on 9/12/23 at 2:02 PM, the Scheduler stated she was responsible for	F 732	affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 9/22/2023 the Administrator re-educated the Director of Nursing and the scheduler regarding the daily nurse staff posting information requirements that all required areas must be accurately filled out to only include direct care staff and to have posted in a prominent place daily. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that through observation including weekends, all of the required daily nurse staffing information is complete, accurate, and displayed in a prominent location. This monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can	

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F 732	Continued From page 13 completing the daily nursing staff posting and daily staffing schedule. She further stated that she had included the Minimum Data Set (MDS) Nurse who was a RN as an RN working for 8 hours on the daily staff posting. On occasion she had included the Assistant Director of Nursing (ADON) as the RN on the staff posting. She confirmed neither staff members were assigned to the medication cart or were assigned directly for residents' care. The scheduler stated she was informed that the MDS nurse or any RN in the building could be included in the daily staffing sheet. She was not aware that the staff should be assigned to the cart or assigned to residents' care. During an interview on 9/12/23 at 2:18 PM, the Director of Nursing (DON) stated he overlooked the daily staffing schedule to ensure the staff were properly scheduled for the day. He indicated he does not verify the daily staffing schedule with the nursing staff posting for accuracy. During an interview on 9/14/23 at 1:53 PM, the Administrator stated that it appeared to be an oversight from the scheduler. The Administrator further stated that the nursing staff directly responsible for resident's care should be included in the daily nursing staff posting. The daily staff postings should be an accurate picture of how many nursing staff were in the building each day.	F 732	modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2022	
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	F 761		10/5/23

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F 761	Continued From page 14 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to remove an expired multi-dose vial of insulin and failed to date opened medications in 1 of 5 medication administration cart (Cart #2). Findings Included: On 9/11/23 at 10:10 AM, an observation of the medication administration cart #2 with Nurse #5 revealed one, half-empty multi-dose vial of Glargine insulin, opened on 8/8/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (5/9/23); one opened and undated multi-dose vial of Levemir insulin. A review of the manufacturer's	F 761	F-761 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 9/11/2023 nurse #5 removed the expired multi-dose vial of insulin and all opened medications without a date were dated for medication administration cart #2. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 9/29/2023 an audit of all 5 medication	

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F 761	Continued From page 15 literature indicated to discard the insulin multi-dose vial 42 days after opening: two opened and undated inhalation containers of Symbicort 160/4.5 mcg (microgram) and one opened and undated inhalation container of Breztri Aerosphere. A review of the manufacturer's literature indicated to discard the inhaler 3 months after removed from the foil pouch; one opened and undated inhalation container of Ventolin. A review of the manufacturer's literature indicated to discard the inhaler 12 months after removed from the foil pouch. On 9/11/23 at 10:30 AM, during an interview, Nurse #5 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials and inhalers in her medication administration cart at the beginning of her shift. The nurse did not administer expired medication this shift. On 9/12/23 at 11:10 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected that no expired items or loose pills be left in the medication carts.	F 761	administration carts was completed by the Director of Nursing to determine if any other medications had expired and if any other medications had been opened without a date. Audit revealed that no other medications were found to have been expired or opened without having been properly dated. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 9/29/2023 the Director of Nursing initiated re-education to all licensed nurses and Medication Aides that are responsible for a medication administration cart regarding the need to remove any expired medications and to date medications upon opening. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Director of Nursing or designee to monitor and ensure that by observation, all of the 5 medication administration carts expired medications have been removed and that opened medications have been dated. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any	

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F 761	Continued From page 16	F 761	additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed label foods in the walk-in refrigerator, walk-in freezer and in two (2) of two (2) nourishment refrigerators. The facility failed to ensure the food in walk-in freezer was free of ice and failed to maintain the back splash behind the stove free of grease. These practices had the	F 812	F-812 (1) How corrective action will be accomplished for resident(s) found to have been affected: All residents have the potential to be affected by this alleged non-compliance.	10/5/23

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F 812	Continued From page 17 potential to affect food being served to residents. Findings included: 1a) An observation of the walk-in refrigerator on 9/11/23 at 10:10 AM revealed an opened bag of sliced cheese and an opened bag of shredded cheese that were not labeled. An opened bag of lettuce that was also not labeled. During an interview with the dietary manager on 9/11/23 at 10:12 AM, she stated the bags of cheese was received on 8/23/23. She stated they had been using cheese in daily meal preparation. The dietary manager stated the bags should be labeled with an opened date. 1b) An observation of the walk-in freezer on 9/11/23 at 10:13 AM revealed an opened 2 pounds (lbs.) bag of vegetables not labeled, a 2lbs opened bag of meat that looked like chicken that did not have a label. During an interview with the dietary manager on 9/11/23 at 10:15 AM she stated the frozen vegetables were fajita vegetables and the meat was diced chicken. She indicated the opened bags should be labelled and dated. The dietary manager stated she was responsible for ensuring that any food placed in the refrigerator or freezer were dated and labeled. She stated she does a daily walk through of the walk-in refrigerator and walk in freezer to ensure all opened foods were labeled and dated. 1 c) An observation of the reach-in refrigerator on 9/11/23 at 10:16 AM revealed two (2) opened 46 fluid ounce (fl. oz.) carton "nectar thick water" with no date or label on them.	F 812	(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 9/13/2023 the Administrator conducted a dietary audit of the walk-in refrigerator, walk-in freezer, and the 2 nourishment refrigerators for accurate dating and labeling of food items along with ensuring that food in the walk-in freezer was free of ice buildup and that the back-splash behind the stove was free of grease. Audit revealed that all food items were labeled and dated appropriately and the back-splash behind the stove was free of grease. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 9/13/2023 the Administrator initiated re-educated to the Dietary Manager including all dietary staff regarding the requirements for proper storing, dating, and labeling of food items in the walk-in refrigerator, walk-in freezer, and the 2 nourishment refrigerators along with ensuring food in walk-in freezer was free of ice build-up and that the back-splash behind the stove remains free of grease. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the	

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F 812	Continued From page 18 During an interview on 9/11/23 at 10:16 AM, the District Dietary Manager stated opened thickened liquids cartons should be labeled with an "open" date and the cartons should be discarded within 7 days after opening. Review of the manufacturer's recommendations revealed thickened water can be stored in the refrigerator for 10 days. Review of the use and storage of food brought in by family or Visitor policy - implemented date 10/2/22 read in part " all food items that are already prepared by the family and visitor brought in must be labeled with content and dated. The prepared food must be consumed by the resident within 7 days. If not consumed within 7 days, food will be thrown away by facility staff". 1d) Observation of the nourishment refrigerator #1 near nursing station #2 on 9/11/23 at 10:20 AM revealed a plastic grocery bag containing 2 lbs. container of yogurt, a 1 lbs. prepacked store brought tamales and on box of prepacked food. The grocery bag did have a label or date on it. During an interview on 9/11/23 at 10:22 AM, the dietary manager stated the food in the grocery bag may be a resident's food that was brought by their families. The dietary manager stated the nursing staff were responsible for dating and labelling the food brought in by families, before placing it in the nourishment refrigerator. 1e) Observation of the nourishment refrigerator #2 near nursing station #1 on 9/11/23 at 10:25 AM revealed a white colored plastic grocery bag containing takeout food that was half consumed,	F 812	Administrator, Director of Nursing, or designee to monitor and ensure that through observation, the walk-in refrigerator, walk-in freezer, and the 2 nourishment refrigerators for accurate dating and labeling of food items along with ensuring food in walk-in freezer is free from ice buildup and that the back-splash behind the stove remains free of grease. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	

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a brown bag with a fast food restaurant log containing some fast food, a 16 ounce of half empty fast food beverage cup, and a 16 fluid ounce bottle half filled with orange colored liquid that were not labeled or date. The nourishment refrigerator had 46 fluid ounce carton "Honey Thickened "liquid that was opened and had no date.

During an interview on 9/11/23 at 10:26 AM, the dietary manager indicated the opened thickened liquid carton could be used up to 7 days from the day of opening. She was unsure when the carton was opened. The dietary manager stated the employees should not be placing personal food in the nourishment refrigerator and the nursing staff were responsible for dating and labeling the food placed in the nourishment refrigerator.

During an interview 09/14/23 09:00 AM, the Director of Nursing (DON) stated all nurses were responsible to ensure all food placed in the nourishment were labeled with resident name and a date it was placed in the refrigerator. Any food that was not consumed should be discarded. DON further stated the nurses were also responsible to date the thickened liquid cartons when they open them. The thickened liquid cartons should be discarded within 7 days of opening.

2) An observation of the walk-in freezer on 9/11/23 at 10:13 AM revealed ice on the freezer compressor coils, ice on the racks and ice on 3 brown colored carboard boxes containing nutritional supplements.

During an interview with the dietary manager on 9/11/23 at 10:15 AM she stated she was unsure

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why there was ice formed on the coils and ice on the racks. She further stated the freezer was recently serviced and repaired.

During an interview on 9/13/23 at 11:45 AM, the maintenance director stated the walk-in freezer was serviced by the contracting service company a month ago. A sensor was placed to ensure the freezer does not accumulate ice. The freezer would go into a defrost mode at times and the ice would melt away. He stated the resolution for this issue was not to have food placed under the compressor and compressor coils. He further stated the facility was looking into buying a new unit.

3) Observation of the cooking stove on 9/11/23 at 10:00 AM revealed the back splash behind the stove with large brown grease stain on them.

During an interview on 9/11/23 at 10:01 AM, the dietary manager stated the back splash behind the stoves were cleaned weekly. However, the back splash was not cleaned last week per schedule. The Dietary manager further stated the dietary cook was responsible for cleaning the stoves and backsplash every Thursday. However, the cook had some other duties to attend to and could not clean the equipment.

During an interview on 9/14/23 at 10:01 AM, the administrator, stated the dietary staff should follow the cleaning schedule to ensure the kitchen equipment were maintained clean, and ensure all food be dated and labeled when placed in the freezer or refrigerator. The Administrator further stated that employees should not be placing personal food in the nourishment refrigerator. Residents' food brought in by families and visitors

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F 812	Continued From page 21 should be labeled and dated by the nursing staff before been placed in the nourishment refrigerator. The staff should also discard these food if the food does not look consumable and if need to discard it earlier than 7 days. The Administrator confirmed the walk-in freezer was recently serviced by the contracted service company and that the facility was looking into a new walk-in freezer unit.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		10/5/23

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and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

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high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

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

§483.75(g) Quality assessment and assurance.

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

(ii) Develop and implement appropriate plans of

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F 867	Continued From page 24 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 observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint surveys dated 8/18/22 to achieve and sustain compliance. This was for recited deficiencies on a recertification survey on 9/14/23. The deficiencies were in the areas of Request/Refuse/Discontinue Treatment; Formulate Advance Directives and Registered Nurse (RN) 8 hours (hrs.)/7 days a week, full time Director of Nursing (DON). The continued failure during the federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F578 - Based on records review, and staff interviews, the facility failed to have Advance Directives (code status) in the residents' records for 1 of 1 resident reviewed for Advance Directives (Resident #3). During the previous recertification and complaint survey on 8/18/22, the facility the facility failed to determine code status on admission for 1 of 5 residents reviewed for Advance Directives. 2. F727 - Based on the Casper Payroll Based	F 867	F-867 (1) How corrective action will be accomplished for resident(s) found to have been affected: F-578- Resident #3's advance directive (code status) was placed in the medical record on 9/14/2023 by the Director of Nursing. F-727- No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: F- 578- On 9/29/2023 and audit was completed by the Director of Nursing to ensure that all residents had an Advanced Directive (code status) in their medical record. Audit revealed that no other residents were affected. F- 727- All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place	

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F 867	Continued From page 25 Journal (PBJ) for fiscal year Quarter 2 2023 (January 1 - March 31) report, record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 8 of 31 days reviewed. (3/4/23, 3/5/23, 3/10/23, 3/11/23, 3/12/23, 3/17/23, 3/18/23, and 3/19/23). During the previous recertification and complaint survey on 8/18/22, the facility failed to schedule a registered nurse (RN) for at least 8 consecutive hours (hrs.) a day for 3 of 48 days reviewed. During an interview on 9/14/23 at 5:30 PM, the Administrator indicated he was hired in February 2023. The administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated citations the Administrator stated the facility had a new management team that includes the Director of Nursing, social workers, and other management staff. The entire team would start looking at the root analysis, plans would be put in place and monitored so that the repeated or reoccurrence of citations would be prevented. The team would continue to grow together to ensure the residents received an excellent quality of care. The old plan would be revisited and analyzed to see where the failures, and breakdown happened. The root cause would be revisited and new interventions, and monitoring tools would be put in place. Audit and education would be completed as needed. The team would continuously monitor until the deficient areas of concerns have been resolved.	F 867	or systemic changes made to ensure that the identified issue does not re-occur in the future: F-578- On 9/21/2023 the Administrator re-educated the Social Worker regarding the requirement that all residents are to have an Advance Directive (code status) in their medical record. F-727- On 9/22/2023 the Administrator re-educated the Director of Nursing and the scheduler regarding the daily Registered Nurse staffing requirements that require at least 8 hours of RN coverage per day, 7 days a week and is to also have specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care. RN staff that do not meet the above criteria will not be counted. To protect residents from similar occurrences, on 9/14/2023 the Regional Director of Clinical Operations re-educated the Quality Assurance and Performance Improvement Committee on maintaining implemented procedures and monitoring interventions that the committee puts into place. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: F-578- Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that by reviewing on admission with the clinical team that the Advance Directive (code	

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F 867	Continued From page 26	F 867	status) is listed and in the medical record along with care plan meeting review to ensure that any changes in the Advance Directive (code status) were updated and in the medical record. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-727- Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that through reviewing the daily staffing schedule in advance with the Director of Nursing and the Scheduler, the required daily Registered Nurse staffing requirements are met. This monitoring process will take place daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can	

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F 867	Continued From page 27	F 867	modify this plan to ensure the facility remains in substantial compliance. F-867- Monitoring will be done by the Administrator and/or the Director of Nursing to ensure that through observation and review, all implemented QAPI plans that were put into place are maintained. This monitoring process will take place weekly for 4 weeks then monthly for 6 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/5/2023	