STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTH AND REHABILITATION	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced, on-site recertification and complaint survey was conducted on 9/11/2023 through 9/13/2023. The facility was found to be incompliance with the requirement CFR.483.73, Emergency Prepardness. Event ID# PVL011.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site recertification and complaint survey was conducted on 9/11/2023 through 9/13/2023. The following intakes were investigated NC00207085, NC00206702, NC00206849, NC00205038 and NC00204033. 2 of the 8 allegations resulted in a deficiency. Event ID #PVL011.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		9/18/23

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

Electronically Signed | 10/04/2023

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the resident and staff, the facility failed to treat a resident in a dignified manner by ensuring a dependent resident could access and activate the call light to request assistance from staff for 1 of 1 resident reviewed for dignity (Resident #122). Resident #122 stated having to yell out for assistance made her feel upset, aggravated and mad. The findings included: Resident #122 was admitted to the facility on 08/18/23 with diagnoses which included quadriplegia (paralysis of all four limbs) and hemiplegia (paralysis of one side of the body). An admission Minimum Data Set (MDS) dated	F 550	1. The facility failed to treat a resident in a dignified manner by ensuring a dependent resident could access and activate the call light to request assistance from staff for 1 of 1 resident reviewed for dignity (Resident #122). Resident #122 stated having to yell out for assistance made her feel upset, aggravated and mad. On 9/11/23, Resident #122 was placed on every 15-minute checks while awaiting the delivery of the new call system. The new breath-activated call system was delivered, installed, and tested for proper functioning on 9/18/23. Resident education provided by the Administrator with successful return demonstration. Care plan and Kardex updated accordingly.	

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F 550	Continued From page 2 08/23/23 revealed Resident #122 was moderately cognitively intact and dependent upon two staff members for bed mobility, eating, toilet use, personal hygiene, and bathing. The resident was coded as having upper and lower extremity impairment on both sides of the body. The MDS revealed Resident #122 had clear speech and was able to make herself understood. On 09/11/23 an observation was conducted of Resident #122 at 11:01 AM. Resident #122 was sitting in a chair with her neck resting back on the chair and a grimace on her face. A square metal flat call bell was placed in the middle of the residents two hands that were lying flat to her side. Resident#122's call light was observed to be off. An interview conducted on 09/11/23 with Resident #122 at 11:01 AM revealed she was having discomfort due to her neck not having a pillow placed underneath. She stated, "I need a drink of water, nobody will help me." The interview revealed Resident #122 could not move her arms to press the call bell that was lying between her arms on her abdomen. The surveyor left the room and told Nurse Aide (NA) #1 Resident #122 needed assistance. An observation was conducted on 09/11/23 at 11:10 AM of NA #1 placing a pillow under the resident's neck for support and obtaining Resident #122's water so she could drink. NA #1 was observed placing the residents call bell back onto her abdomen in between her arms before she left the room. After NA #1 left the room, Resident #122 stated, "Do you see what I mean, they just don't understand".	F 550	2. All current facility residents are at risk of being affected by the deficient practice. On 9/13/23 a full house audit was completed by the Maintenance Director to ensure current facility residents had an appropriate working call light to meet their needs. No further concerns were noted during the audit. 3. To ensure this deficient practice does not recur we put the following into place; effective 9/18/23, current facility and agency staff were educated by the staff development coordinator on resident rights to be treated in a dignified manner including the right to have a call system that meets their care needs. New facility and agency staff and staff that were unable to complete education by 9/18/23 will be educated prior to working their first or next shift. 4. The Maintenance Director or Administrator will complete audits on facility call lights to ensure residents have a properly functioning call system to meet their needs 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks. The data from the audits will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Administrator monthly for 3 months and changes will be made to the plan as necessary to maintain compliance. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or	

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F 550	Continued From page 3 On 09/11/23 at 11:15 AM an interview was conducted with NA #1. She stated Resident #122 normally would not use her call bell when she needed something. She stated the resident would just yell out if she needed assistance. NA #1 stated she went into Resident #122's room to complete rounding every 2 hours. The interview revealed the last time she had walked into the room with Resident #122 was to assist her with the breakfast meal around 9:00 AM. An interview was conducted on 09/12/23 at 11:10 AM with Family Member #1 and Resident #122. Family Member #1 stated when he came to the facility that day, Resident #122 was yelling out that she needed assistance. He stated he felt like the facility could get a whistle or call bell the resident could blow into to turn the light on for assistance, so she did not have to yell. Resident #122 stated she could not move her arms to press the call bell, and she refused to have the cord draped over her when she was unable to press the call bell. She stated having to yell for staff made her upset, aggravated and mad with staff. Resident #122 stated she often had to wait in a soiled brief and was left without water because she could not get staff into her room. The interview revealed Resident #122 felt like the staff were not listening to her because she had told them she would be able to use a call bell that you could blow into however they had not ordered it. On 09/12/23 at 10:20 AM an observation was conducted of Resident #122's call bell located behind her on the bedside dresser. Resident #122 stated she needed her blinds closed and a drink of water during the observation. The	F 550	adjustments. 5. Completion Date: 9/18/23	

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F 550	Continued From page 4	F 550		

surveyor left the room and notified NA #2.

An interview conducted on 09/12/23 at 12:13 PM with NA #2 revealed Resident #122 had been yelling out if she needed assistance since the time she was admitted. She stated the resident was yelling out every 20-30 minutes because she could not use her call bell. NA #2 stated she had witnessed Resident #122 become frustrated with staff because she was unable to use her call bell and had trouble expressing her needs.

An interview conducted on 09/12/23 at 2:25 PM with Nurse #1 revealed Resident #122 would yell out if she needed assistance and could not use her call bell because she could not move her arms. She stated she did not recall NA #2 telling her the resident could not use her call bell, but she knew it anyway. The interview revealed she had not reported it to the Director of Nursing because she felt he was aware.

An interview conducted on 09/12/23 at 10:33 AM with Certified Occupational Therapist Assistant (COTA) #1 revealed she had been working with Resident #122 and she had spoken with staff, and they were placing her call light behind her shoulder at one time, but the resident said it was uncomfortable. She stated the staff placed the call light under her chin after, but the resident stated that was also uncomfortable. The interview revealed the resident was yelling out to staff when they passed by to obtain assistance.

An interview was conducted on 09/12/23 at 11:30 AM with Physical Therapy Assistant (PTA) #1 revealed she had been working with Resident #122 for therapy. The interview revealed PTA #1 had overheard Resident #122 yelling out for

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F 550	Continued From page 5 assistance on occasions. She stated she thought the resident just refused her call bell and preferred to yell. An interview was conducted on 09/12/23 at 11:45 AM with the Director of Nursing (DON). During the interview he stated Resident #122 had tried two different call bells. He stated he was aware the resident was not using the call bell and thought another call bell had been ordered by the Business Office Manager because he was aware Resident #122 was yelling out into the hall for staff assistance. The DON stated no resident should have to yell for assistance. An interview conducted on 09/13/23 at 3:00 PM with the Administrator revealed he was new to the facility and had just started the week prior. He stated he was not aware of Resident #122 being unable to use her call bell and the facility had a new bell on order since the survey started. He stated no resident should have to yell for assistance from staff.	F 550		
F 558 SS=G	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the resident and staff, the facility failed provide an adaptive call bell the resident could activate to call for assistance. This resulted	F 558	1. The facility failed to provide an adaptive call bell the resident could activate to call for assistance. This resulted in the resident relying on her	9/18/23

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F 558	Continued From page 6 in the resident relying on her voice to yell for assistance. This deficient practice occurred for 1 of 1 resident reviewed for accommodation of needs (Resident #122). The findings included: Resident #122 was admitted to the facility on 08/18/23 with diagnosis which included quadriplegia (paralysis of all four limbs) and hemiplegia (paralysis of one side of the body). An admission Minimum Data Set (MDS) dated 08/23/23 revealed Resident #122 was moderately cognitively intact and dependent upon two staff members for bed mobility, eating, toilet use, personal hygiene, and bathing. The resident was coded as having upper and lower extremity impairment on both sides of the body. On 09/11/23 an observation was conducted of Resident #122 at 11:01 AM. Resident #122 was sitting in a chair with her neck resting back on the chair and a grimace on her face. A square metal flat call bell was placed in the middle of the resident's two hands that were lying flat to her side. Resident#122's call light was observed to be off. An interview conducted on 09/11/23 with Resident #122 at 11:01 AM revealed she was having discomfort due to her neck not having a pillow placed underneath. She stated, "I need a drink of water, nobody will help me." The interview revealed Resident #122 could not move her arms to press the call bell that was lying between her arms on her abdomen. She stated, "they need to get me a call bell I can blow into." She stated she had expressed to staff she could not use the call	F 558	voice to yell for assistance. This deficient practice occurred for 1 of 1 resident reviewed for accommodation of needs (Resident #122). Upon notification of the issue the facility ordered a specialized call light system on 9/12/23 for resident #122 and placed resident on every 15-minute checks while awaiting the delivery of the new system. The new call light system was delivered and installed on 9/18/23. 2. All current facility residents are at risk of being affected by the deficient practice. On 9/13/23 a full house audit was completed by the maintenance director to ensure current facility residents had an appropriately functioning call light system to meet their needs and to ensure the residents were able to use their call light. No further concerns were noted during audit. 3. To ensure this deficient practice does not recur we put the following into place; effective 9/18/23, current facility and agency staff were educated by the staff development coordinator on resident rights of accommodation of needs, including right to have a call system that the resident is able to effectively utilize and in the event a resident can not use the call light system, staff are to notify the Administrator, Director of Nursing, or Maintenance Director. New facility and agency staff and staff that were unable to complete education by 9/18/23 will be educated prior to working their first or next shift.	

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F 558	Continued From page 7 bell, but nothing had changed. The surveyor left the room and told Nurse Aide (NA) #1 Resident #122 needed assistance. An observation was conducted on 09/11/23 at 11:10 AM of NA #1 placing a pillow under the resident's neck for support and obtaining Resident #122's water so she could drink. NA #1 was observed placing the residents call bell back onto her abdomen in between her arms before she left the room. On 09/11/23 at 11:15 AM an interview was conducted with NA #1. She stated Resident #122 normally would not use her call bell when she needed something. She stated the resident would just yell out if she needed assistance. NA #1 stated she went into Resident #122's room to complete rounding every 2 hours. The interview revealed she placed the call light back onto her abdomen because she thought she had seen her arm move in the past. The interview revealed the last time she had assisted the resident was to assist her with the breakfast meal around 9:00 AM. She stated she did have access to the resident's care plan but did not look at it prior to entering the resident's room. An interview was conducted on 09/12/23 at 11:10 AM with Family Member #1 and Resident #122. Family Member #1 stated when he came to the facility that day Resident #122 was yelling out for assistance. He stated he felt like the facility could get a whistle or call bell the resident could blow into to turn the light on for assistance, so she did not have to yell. Resident #122 stated she could not move her arms to press the call bell, and she refused to have the cord draped over her when she was unable to press the call bell. Resident	F 558	4. The Maintenance Director or Administrator will complete audits on facility call lights to ensure residents have properly functioning call lights to accommodate their needs 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks. The data from the audits will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meetings by the Administrator monthly for 3 months and changes will be made to the plan as necessary to maintain compliance. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments. 5. Completion Date: 9/18/23	

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F 558	Continued From page 8	F 558		

#122 stated she often had to wait in a soiled brief and was left without water because she could not get staff into her room.

On 09/12/23 at 10:20 AM an observation was conducted of Resident #122's call bell located behind her on the bedside dresser. Resident #122 stated she needed her blinds closed and a drink of water during the observation. The surveyor left the room and notified NA #2. Resident #122's call light was not on nor was she yelling when the surveyor entered the room.

An interview conducted on 09/12/23 at 12:13 PM with NA #2 revealed Resident #122 had been yelling out if she needed assistance since the time she was admitted. She stated the resident was yelling out every 20-30 minutes because she could not use her call bell. NA #2 stated even if the call bell was placed beside her head the resident still could not turn her neck enough to press the button. She stated she had told Nurse #1 a few weeks ago the resident was unable to use the call bell but never heard anything else.

An interview conducted on 09/12/23 at 2:25 PM with Nurse #1 revealed Resident #122 would yell out if she needed assistance and could not use her call bell because she could not move her arms. She stated she did not recall NA #2 telling her the resident could not use her call bell, but she knew it anyway. The interview revealed she had not reported it to the Director of Nursing because she felt he was aware.

An interview conducted on 09/12/23 at 10:33 AM with Certified Occupational Therapist Assistant (COTA) #1 revealed she had been working with

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Resident #122 on stretching and contracture prevention. She stated the resident's muscles were very tight and she had been moving the resident's arms to stretch them during the treatment encounters. She stated the only movement she had seen from the resident's arms was when she actively moved them outward, and the muscle tone would move them back in. She stated the resident was unable to actively move her arms or legs herself. She stated she had spoken with staff, and they were placing her call light behind her shoulder at one time, but the resident said it was uncomfortable. She stated the staff placed the call light under her chin after, but the resident stated that was also uncomfortable. The interview revealed the resident was yelling out to staff when they passed by to obtain assistance. She stated the therapy department had not explored other options for a call bell for Resident #122 and was unsure of the call bell options available.

An interview was conducted on 09/12/23 at 11:30 AM with Physical Therapy Assistant (PTA) #1 revealed she had been working with Resident #122 for therapy. She stated they were working on range of motion on her knees and gentle stretching of both legs. The interview revealed she had completed caregiver training with bed positioning to prevent skin breakdown. She stated Resident #122 could not move her legs or arms. The interview revealed normally did not pay attention to the call bell when she entered the room. She stated she knew the resident did not like the call bell on her or below her chin. She stated she had not looked into getting the resident another type of call bell and the therapy department could investigate further into getting the resident a call bell she could activate.

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F 558	Continued From page 10 An interview was conducted on 09/12/23 at 11:45 AM with the Director of Nursing (DON). During the interview he stated Resident #122 had tried two different call bells. He stated the first one was a flat pancake style bell that she could not use so they switched to a larger square hard metal call bell that sat up onto the bedside table. He stated he was aware the resident was not using the call bell and thought another call bell had been ordered by the Business Office Manager. He stated he did not know a date but would check the invoices. The interview revealed the DON was aware Resident #122 was yelling out into the hall for staff assistance. An interview conducted on 09/13/23 at 3:00 PM with the Administrator revealed he was new to the facility and had just started the week prior. He stated he was not aware of Resident #122 being unable to use her call bell and the facility had a new bell on order since the survey started.	F 558		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		9/18/23

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F 756	Continued From page 11 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and the Medical Director (MD), The Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 2 of 6 residents reviewed for unnecessary medications (Resident #10 and #40). The findings included: 1. Resident #10 was admitted to the facility on 03/22/23 with diagnoses that included diabetes mellitus (DM).	F 756	1. The Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 2 of 6 residents reviewed for unnecessary medications (Resident #10 and #40). On 9/13/23, the Director of Nursing (DON) notified the medical provider of medication errors and no new orders were received. On 9/13/23, the Regional Director of Clinical Services (RDCS) notified the Pharmacy Consultant of deficient practice and provided reeducation on (Regulation F756) the medication regime review policy and the	

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	345083	A. BUILDING _____ B. WING _____	C 09/13/2023

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F 756	Continued From page 12 The care plan initiated on 04/28/23 indicated Resident #10 was at risk of fluctuating blood sugars due to diabetes. The goal was to remain free of complications related to diabetes through the next review date. Intervention included to administer medications as ordered. The significant change in status Minimum Data Set (MDS) assessment dated 06/15/23 coded Resident #10 with intact cognition and indicated he was receiving insulin daily during the 7-day assessment period. Review of physician's orders dated 07/05/23 revealed Resident #10 had an order to receive 10 units of Novolog insulin subcutaneously 3 times daily with meals for diabetes. The order specified to hold the insulin when Resident #10's capillary blood glucose (CBG) was lower than 200 milligrams per deciliter (mg/dL). On 08/17/23, the Novolog order changed to 10 units subcutaneously once daily in the morning with the same parameter of holding the insulin when the CBG was lower than 200 mg/dl. A review of medication administration records (MARs) on 09/11/23 indicated Resident #10 had received 10 unit of Novolog insulin subcutaneously erroneously from 5 different nurses for 19 times within 69 days (from 07/05/23 through 09/11/23) when his CBGs were less than 200 mg/dL prior to the insulin injections for the following doses: - 07/06/23 noon when CBG = 182 mg/dL - 070/7/23 morning when CBG = 176 mg/dL - 07/08/23 morning when CBG = 161 mg/dL - 07/08/23 noon when CBG = 172 mg/dL	F 756	facilities expectation for irregularities to be addressed during monthly medication reviews. Both residents blood sugars are stable currently. 2. Current facility residents with insulin orders with parameters are at risk of being affected by this deficient practice. Resident insulin orders with parameters were reviewed for irregularities by the RDCS on 9/13/23. No further issues were noted during the audit. 3. To ensure this deficient practice does not recur we put the following into place; The RDCS completed education with the pharmacy consultant and the DON on 9/13/23 the medication regimen review policy and the facilities expectation for irregularities to be addressed by the consultant pharmacist during monthly medication reviews. New DONs and consultant pharmacists will be educated upon hire by the RDCS. The DON will review pharmacy consultant report and recommendations monthly to ensure residents on insulin treatment are reviewed by the consulting pharmacist with appropriate recommendations made to identify drug irregularities. 4. The DON will monitor residents on insulin treatment with parameters to ensure consulting pharmacist makes recommendations as necessary to identify drug irregularities. Monitoring will be completed twice weekly for 4 weeks then weekly for 8 weeks. The facility will monitor the corrective actions to ensure	

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F 756	Continued From page 13 - 07/08/23 evening when CBG = 147 mg/dL - 07/09/23 noon when CBG = 137 mg/dL - 07/10/23 evening when CBG = 116 mg/dL - 07/11/23 evening when CBG = 171 mg/dL - 07/16/23 morning when CBG = 120 mg/dL - 07/16/23 noon when CBG = 100 mg/dL - 07/16/23 evening when CBG = 132 mg/dL - 07/20/23 morning when CBG = 173 mg/dL - 07/20/23 noon when CBG = 82 mg/dL - 07/20/23 evening when CBG = 188 mg/dL - 07/22/23 evening when CBG = 191 mg/dL - 08/06/23 morning when CBG = 197 mg/dL - 08/06/23 evening when CBG = 178 mg/dL - 08/29/23 morning when CBG = 94 mg/dl - 09/07/23 morning when CBG = 106 mg/dl Review of medical records revealed Resident #10's CBGs were stable at the baselines ranged from 76 to 280 mg/dl over the past 3 months. Review of medical record revealed the Consultant Pharmacist had conducted monthly medication regimen reviews for Resident #10 in the past 5 months on 04/20/23, 05/21/23, 06/25/23, 07/21/23, and 08/22/23. However, he did not identify any drug irregularities related to unnecessary insulin and did not make any specified recommendations to the physician or nursing staff to correct the error. During an interview conducted on 09/11/23 at 12:34 PM, Resident #10 stated his CBGs were stable in the past 3 months. 2. Resident #40 was admitted to the facility on 02/07/23 with diagnoses included diabetes mellitus (DM). The care plan initiated on 03/12/23 revealed	F 756	that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months and make changes to the plan as necessary. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments. 5. Completion Date: 9/18/23	

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F 756	Continued From page 14	F 756		

Resident #40 was at risk for fluctuating blood sugars due to diabetes. The goal was to remain free of complications related to diabetes through the next review date. Intervention included to administer medications as ordered.

Review of physician's orders dated 06/17/23 revealed Resident #40 had an order to receive 20 units of Humalog insulin subcutaneously 3 times daily before meals. The physician did not set any parameters for this order.

The quarterly MDS assessment dated 08/18/23 coded Resident #10 with intact cognition and indicated she was receiving insulin daily during the 7-day assessment period.

Review of medical records revealed the Consultant Pharmacist had conducted monthly medication regimen reviews for Resident #40 in the past 7 months on 02/20/23, 03/21/23, 04/20/23, 05/20/23, 06/25/23, 07/21/23, and 08/21/23. The Consultant Pharmacist did not identify any drug irregularities related to the incorrect holding of insulin and did not make any specified recommendations to the physician or nursing staff to correct the error.

During an interview conducted on 09/11/23 at 1:04 PM, Resident #40 stated she was not getting her insulin as ordered at times.

A review of MARs on 09/13/23 revealed Resident #40's Humalog had been held incorrectly by 2 different nurses for 14 times within 74 days (from 07/01/23 through 09/12/23) for the following doses due to either "held per parameters" or "Insulin not required":

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F 756	Continued From page 15	F 756		

- 07/07/23 noon
- 07/12/23 noon
- 07/17/23 noon
- 07/22/23 noon
- 07/26/23 evening
- 07/31/23 evening
- 08/10/23 noon
- 08/23/23 evening
- 08/24/23 evening
- 09/02/23 noon
- 09/03/23 noon
- 09/03/23 evening
- 09/11/23 noon
- 09/12/23 evening

Review of medical records revealed Resident #40's CBGs were stable at the baselines. It ranged mostly from 100s to low 300s mg/dl in the past 3 months.

During a phone interview conducted on 09/13/23 at 11:06 AM, the Consultant Pharmacist stated it was an error to administer Novolog insulin without following the parameters for Resident #10 and added the nurse should have at least consulted the physician before holding Resident #40's Humalog insulin. He explained he had to cover multiple areas when he performed the monthly medication regimen reviews. The Consultant Pharmacist further stated his failure to identify the drug irregularities related to insulin administration for Resident #10 and Resident #40 was an oversight.

A joint interview was conducted with the Interim Director of Nursing (IDON) and the Administrator on 09/13/23 at 1:37 PM. Both expected the Consultant Pharmacist to identify and report the drug irregularities in a timely manner when

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F 756	Continued From page 16 performing the monthly medication regimen reviews. During a phone interview conducted on 09/13/23 at 2:17 PM, the Medical Director (MD) expected the Consultant Pharmacist to identify, document, and report the drug irregularities in a timely manner when performing the monthly medication regimen reviews. It was her expectation for nurses to follow the order and check the set parameter carefully before administering insulin for Resident #10, and to consult her before making any changes to the insulin order for Resident #40.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and the Medical Director (MD), the facility failed to prevent significant medication errors when nurses failed to follow the physician's parameter as ordered during insulin administration. As a result, Resident #10 had received 19 doses of unnecessary Novolog insulin within 69 days, and Resident #40 had missed 14 doses of Humalog insulin within 73 days. This affected 2 of 6 residents reviewed for unnecessary medications (Resident #10 and #40). The findings included: 1.Resident #10 was admitted to the facility on	F 760	1. The facility failed to prevent significant medication errors when nurses failed to follow the physician's parameter as ordered during insulin administration. As a result, Resident #10 had received 19 doses of unnecessary Novolog insulin within 69 days, and Resident #40 had missed 14 doses of Humalog insulin within 73 days. This affected 2 of 6 residents reviewed for unnecessary medications (Resident #10 and #40). On 9/13/23, the director of nursing (DON) notified the medical provider of medication errors. At which time no new orders were received. Both residents□ blood sugars are stable currently.	9/18/23

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F 760	Continued From page 17 03/22/23 with diagnoses included diabetes mellitus (DM). The care plan initiated on 04/28/23 indicated Resident #10 was at risk of fluctuating blood sugars due to diabetes. The goal was to remain free of complications related to diabetes through the next review date. Intervention included to administer medications as ordered. The significant change in status Minimum Data Set (MDS) assessment dated 06/15/23 coded Resident #10 with intact cognition and indicated he was receiving insulin daily during the 7-day assessment period. Review of physician's orders dated 07/05/23 revealed Resident #10 had an order to receive 10 units of Novolog insulin subcutaneously 3 times daily with meals for diabetes. The order specified to hold the insulin when Resident #10's capillary blood glucose (CBG) was lower than 200 milligrams per deciliter (mg/dL). On 08/17/23, the Novolog order changed to 10 units subcutaneously once daily in the morning with the same parameter of holding the insulin when the CBG was lower than 200 mg/dl. A review of medication administration records (MARs) on 09/11/23 indicated Resident #10 had received 10 unit of Novolog insulin subcutaneously erroneously from 5 different nurses for 19 times within 69 days (from 07/05/23 through 09/11/23) when his CBGs were less than 200 mg/dL prior to the insulin injections for the following doses: - 07/06/23 noon when CBG = 182 mg/dL - 070/7/23 morning when CBG = 176 mg/dL	F 760	2. Current facility residents with insulin orders with parameters are at risk of being affected by this deficient practice. Resident insulin orders with parameters were reviewed for errors by the Regional Director of Clinical Services (RDCS) on 9/13/23. No further issues were noted during the audit. 3. To ensure this deficient practice doesn□t recur the facility has put the following into place; effective 9/18/23, the staff development coordinator (SDC) educated the facility and agency licensed nurses and medication aides on medication administration, processes to help reduce the risk of medication errors, insulin administration, and following parameters for insulin administration. Newly hired facility and agency licensed nurses and medication aides not receiving education by 9/18/23 will be educated upon hire or prior to working their first shift. 4. DON will monitor residents on insulin treatment with parameters to ensure medication is given as ordered. Monitoring will be completed for five (5) residents twice weekly for 4 weeks then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months and	

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F 760	Continued From page 18 - 07/08/23 morning when CBG = 161 mg/dL - 07/08/23 noon when CBG = 172 mg/dL - 07/08/23 evening when CBG = 147 mg/dL - 07/09/23 noon when CBG = 137 mg/dL - 07/10/23 evening when CBG = 116 mg/dL - 07/11/23 evening when CBG = 171 mg/dL - 07/16/23 morning when CBG = 120 mg/dL - 07/16/23 noon when CBG = 100 mg/dL - 07/16/23 evening when CBG = 132 mg/dL - 07/20/23 morning when CBG = 173 mg/dL - 07/20/23 noon when CBG = 82 mg/dL - 07/20/23 evening when CBG = 188 mg/dL - 07/22/23 evening when CBG = 191 mg/dL - 08/06/23 morning when CBG = 197 mg/dL - 08/06/23 evening when CBG = 178 mg/dL - 08/29/23 morning when CBG = 94 mg/dl - 09/07/23 morning when CBG = 106 mg/dl Review of medical records revealed Resident #10's CBGs were stable at the baselines ranged from 76 to 280 mg/dl in the past 3 months. During an interview conducted on 09/11/23 at 12:34 PM, Resident #10 stated he had received insulin as ordered in timely manner and added his CBGs were stable in the past 3 months. An interview was conducted on 09/12/23 at 2:51 PM. Nurse #2 confirmed she had administered Novolog insulin for Resident #10 several times when his CBGs were lower than 200 mg/dl and acknowledged that it was an error. She explained that she had forgotten to check the parameter set by the physician before administering the insulin. . During an interview conducted on 09/12/23 at 3:15 PM, Nurse #3 confirmed she had administered Novolog insulin for Resident #10 several times when his CBGs were less than 200	F 760	changes will be made to the plan as necessary. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments. 5. Completion Date: 9/18/23	

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F 760	Continued From page 19	F 760		

mg/dl and acknowledged that it was an error. She stated that she could have been distracted during medication pass and forgotten to follow the parameter with the Novolog order.

An interview was conducted with the Unit Manager (UM) on 09/12/23 at 3:21 PM. She expected nursing staff to follow physician's order and review the parameter before administering medication. She stated Resident #10's Novolog should be held when his CBGs were less than 200 mg/dl and acknowledged that it was an error.

2. Resident #40 was admitted to the facility on 02/07/23 with diagnoses included diabetes mellitus (DM).

The care plan initiated on 03/12/23 revealed Resident #40 was at risk for fluctuating blood sugars due to diabetes. The goal was to remain free of complications related to diabetes through the next review date. Intervention included to administer medications as ordered.

Review of physician's orders dated 06/17/23 revealed Resident #40 had an order to receive 20 units of Humalog insulin subcutaneously 3 times daily before meals. The physician did not set any parameters for this order.

The quarterly MDS assessment dated 08/18/23 coded Resident #10 with intact cognition and indicated she was receiving insulin daily during the 7-day assessment period.

During an interview conducted on 09/11/23 at 1:04 PM, Resident #40 stated she was not getting her insulin as ordered at times.

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F 760	Continued From page 20	F 760		

A review of MARs on 09/13/23 revealed Resident #40's Humalog had been held incorrectly by 2 different nurses for 14 times within 74 days (from 07/01/23 through 09/12/23) for the following doses due to either "held per parameters" or "Insulin not required":

- 07/07/23 noon
- 07/12/23 noon
- 07/17/23 noon
- 07/22/23 noon
- 07/26/23 evening
- 07/31/23 evening
- 08/10/23 noon
- 08/23/23 evening
- 08/24/23 evening
- 09/02/23 noon
- 09/03/23 noon
- 09/03/23 evening
- 09/11/23 noon
- 09/12/23 evening

Review of medical records revealed Resident #40's CBGs were stable at the baselines ranged mostly from 100s to low 300s mg/dl in the past 3 months.

During an interview conducted on 09/13/23 at 9:11 AM, Nurse #3 confirmed she had held Resident #40's Humalog 13 times since July and acknowledged that it was an error. She thought Resident #40 had a parameter to hold the Humalog when her CBGs were below 200 mg/dl and added she should have reviewed each order carefully before administering or holding the insulin.

An interview was conducted with the UM on 09/13/23 at 9:25 AM. She expected the nurse to

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F 760	Continued From page 21 follow physician's order and consult the physician before holding Resident #40's insulin. During a phone interview conducted on 09/13/23 at 11:06 AM, the Consultant Pharmacist stated it was an error to administer Novolog insulin without following the parameters for Resident #10 and added the nurse should have at least consulted the physician before holding Resident #40's Humalog insulin. He was unsure the above incidents would be considered as a significant medication error. A joint interview was conducted with the Interim Director of Nursing (IDON) and the Administrator on 09/13/23 at 1:37 PM. Both expected nursing staff to follow physician's order when performing medication pass and contact the physician before making any changes to the order. The IDON and the Administrator acknowledged that it was a medication error but denied it was a significant medication error. During a phone interview conducted on 09/13/23 at 2:17 PM, the Medical Director (MD) expected nurses to follow the order and check the parameter carefully before administering insulin for Resident #10 and to consult her before making any changes to the insulin order for Resident #40. She was unclear about the definition of significant medication error and unable to determine it was a significant medication error.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		9/18/23

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F 761	Continued From page 22 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews, the facility failed to remove expired over the counter (OTC) medications in accordance with the manufacturer's expiration date for 1 or 2 medication rooms observed during medication storage checks (Medication Room B). The findings included: A medication storage audit was conducted on 09/12/23 at 5:45 PM for Medication Room B in the presence of the Unit Manager (UM). The following expired medications were found in Medication Room B and ready to be used:	F 761	1. The facility failed to remove expired over the counter (OTC) medications in accordance with the manufacturer's expiration date for 1 or 2 medication rooms observed during medication storage checks (Medication Room B). Upon notification the director of nursing (DON) removed the expired medications and disposed of them as indicated. 2. All current facility residents are at risk of being affected by this deficient practice. The Unit Manager audited all facility medication storage on 9/14/23 to ensure	

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F 761	Continued From page 23 a. 9 unopened bottles of Senna syrup expired on 07/31/22. Each bottle contained 237 milliliters (ml) of syrup. b. 1 opened bottle contained 100 tablets of Calcium 600 milligrams (mg) with Vitamin D3 expired on 10/31/22. c. 5 unopened bottles of Geri-Lanta antacid suspension expired on 06/30/23. Each bottle contained 335 ml of suspension. During an interview conducted on 09/12/23 at 5:51 PM, the UM acknowledged that the above medications had expired and needed to be discarded. She stated the central supply clerk was responsible to check and rotate the OTC medications on regular basis. She audited medication storage at times as a follow-up to ensure compliance. In addition, the Consultant Pharmacist would spot check medication storage during his monthly visits. An interview was conducted with the Central Supply Clerk on 09/12/23 at 5:57 PM. He denied it was his responsibility to check the expiration and rotate the OTC medications as he did not even have the key to access the medication rooms in the facility. A joint interview was conducted on 09/13/23 at 2:17 PM with the Interim Director of Nursing (IDON) and the Administrator. Both stated the UM was responsible to oversee medication storage in the facility. It was their expectation for all the nursing staff to follow facility's medication storage policy and procedure to ensure the facility was free of expired medication.	F 761	medications were not expired and stored properly. No further expired medications were found. 3. To ensure the deficient practice doesn□t recur the facility has put the following into place; effective 9/18/23, the staff development coordinator (SDC) completed education with facility and agency licensed nurses, certified medication aides, and central supply clerk on medication and biological storage policy, and ensuring medication is not expired and to remove medication that is expired. New agency and facility licensed nurses, certified medication aides, and central supply clerks and staff unable to complete education by 9/18/23 will be educated upon hire and prior to working their next shift. 4. The unit managers or DON will audit medication storage areas 2 times a week for 4 weeks, then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months and changes will be made to the plan as necessary. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments.	

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F 761	Continued From page 24	F 761	5. Completion Date: 9/18/23	
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, record review and staff interviews, the facility failed to remove expired food items in 2 of 2 nourishment rooms. These practices had the potential to affect food served to residents. Findings included: An observation and interview conducted with Nurse Aide (NA) #3 in nourishment room on hall 200 on 09/11/23 at 11:00 AM revealed two fat free milk cartons with expiration date of 09/09/23, pimento cheese sandwich with discard date	F 812	1. The facility failed to remove expired food items in 2 of the 2 nourishment rooms. These practices had the potential to affect food served to residents. Upon notification on 9/11/23, the expired items were removed by the nursing staff. 2. All current facility residents have the potential to be affected by this deficient practice. Food storage areas were audited by the dietary manager on 9/14/23 to ensure food was in date and stored correctly. No further issues were noted.	9/18/23

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F 812	Continued From page 25 08/20/23, and tuna sandwich with discard date 09/10/23. NA #3 further revealed staff had been educated to throw away expired food and drinks and should have been thrown away already. An observation and interview conducted with Nurse #4 in nourishment room on hall 100 on 09/11/23 at 11:15 AM revealed a tuna salad sandwich with discard date 08/29/23. Nurse #4 further revealed dietary was responsible for checking nourishment rooms daily, but nursing staff was also educated to throw away expired food and drinks. Nurse #4 indicated the expired sandwich should have already been discarded. An interview conducted with Dietary Manager (DM) on 09/12/23 at 11:45 AM revealed dietary was primarily responsible for checking the nourishment rooms twice a day. The DM further revealed nursing staff were also educated on discarding expired food if observed in the nourishment rooms. The DM stated she expected expired food to not be in the nourishment rooms and should have been discarded. An interview conducted with the Administrator and Director of Nursing (DON) on 09/13/23 at 2:15 PM revealed they were not aware expired food and drink were observed in both nourishment rooms. The DON further revealed nursing staff had been educated during orientation to throw away discarded food and drink and had been educated by dietary staff. The Administrator indicated he expected the expired food or drinks to be discarded from the nourishment rooms.	F 812	3. To ensure the deficient practice does not recur the facility has put the following into place; the staff development coordinator (SDC) educated current facility dietary staff and current facility and agency nursing staff on facilities food storage policy. The dietary staff were also educated about checking the nourishment rooms daily for expired foods and to remove the expired items. The nursing staff were also educated to remove expired items when identified by 9/18/23. Newly hired dietary staff and nursing staff and staff unable to complete education prior to 9/18/23 will complete education upon hire or before next scheduled shift. 4. The dietary manager will audit facility food storage 5 times a week for 4 weeks, 2 times a week for 4 weeks, and weekly for 4 weeks The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing monthly for three (3) months and make changes to the plan as necessary. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments. 5. Completion Date: 9/18/23	
F 867 SS=D	QAPI/QAA Improvement Activities	F 867		9/18/23

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F 867	Continued From page 26 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, 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	F 867		

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F 867	Continued From page 27	F 867		

prevent adverse events.

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; 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

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F 867	Continued From page 28 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor	F 867	1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in	

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F 867	Continued From page 29 interventions previously put in place following the recertification survey of 4/27/2022. The repeat deficiency was cited on the current recertification survey of 9/13/2023 in the area of Infection Control (F880). The facility's continued failure during two Federal Surveys showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: F-880: Based on record review, observations and staff interviews, the facility failed to implement their infection control policies for Covid-19 when Nurse #5 failed to change into full Personal Protective Equipment (PPE), to include changing out of her surgical mask and applying a N95 mask, prior to entering a room that was on enhanced droplet precautions for Covid-19. This observation occurred during an active outbreak of Covid-19 for 1 of 2 rooms on enhanced droplet precautions for positive Covid-19. During the recertification and complaint survey on 4/27/2022 the facility was cited for failure to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for Covid-19 when 1 of 3 staff members failed to wear full Personal Protective Equipment (PPE) when entering a resident's room on enhanced droplet precautions. The Administrator was interviewed on 9/13/2023 at 2:00 PM: The Administrator stated he was the head of the QAA committee which met monthly. He revealed he completed a QA assessment tool monthly to determine if an issue needed to be addressed. He indicated if an issue was identified	F 867	place following the recertification survey of 4/27/2022. The repeat deficiency was cited on the current recertification survey of 9/13/2023 in the area of Infection Control (F880). The facility's continued failure during two Federal Surveys showed a pattern of the facility's inability to sustain an effective QAA program. Facility had an Ad Hoc QAPI meeting on 9/14/23 to review repeat citations and plans put in place to prevent future citations and have a successful and productive Quality Assurance and Performance Improvement (QAPI) Committee. 2. All residents have the potential to be affected by this deficient practice. The facility initiated a weekly QAPI risk meeting to review the results of the ongoing audits per the plan of correction and its continued effectiveness on 9/18/23. Changes will be made to the plan as necessary to maintain compliance and to ensure an effective QAPI program to prevent repeat citations. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Regional Director of Clinical Services educated QAPI committee members on maintaining an effective QAPI program and monitoring system to prevent repeat citations on 9/18/2023. QAPI meetings to be held weekly, monthly, and as needed by the facility QAPI committee with oversight by the regional team. New or current	

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F 867	Continued From page 30 he put a Performance Improvement Plan in place and identify a root cause of the failure. Education would be completed with staff and audits conducted. The audits would be brought to him and reviewed, and he would then bring to the monthly QAA meeting. Any changes to the plan would be corrected at that time and implemented. The audits are kept in a notebook, and he was responsible for bringing the binder to the QAA meeting. The Administrator stated he felt the root cause of the repeated infection control deficiency was lack of education, and that the facility had to utilize agency staff for licensed nurses. He stated he was responsible for ensuring staff education was completed and that staff understood their responsibility in the QAA process.	F 867	members of the QAPI committee not educated by 9/18/23 will be educated upon hire or next shift worked. 4. The Regional Director of Clinical Services (RDCS) or Vice President of Operations (VPO) will monitor weekly for 4 weeks then, monthly for 2months for compliance with daily/weekly/monthly/PRN Ad Hoc QAPI risk review of audits of repeat tags for proper monitoring of effectiveness by QAPI committee to maintain an effective QAPI program that prevents repeat citations by effective monitoring. Results of monitoring will be presented to the Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee and RDCS or VPO will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 9/18/23	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		9/18/23

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F 880	Continued From page 31 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 32 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement their infection control policies for Covid-19 when Nurse #5 failed to change into full Personal Protective Equipment (PPE), to include changing out of her surgical mask and applying a N95 mask, prior to entering a room that was on enhanced droplet precautions for Covid-19. This observation occurred during an active outbreak of Covid-19 for 1of 2 resident rooms on enhanced droplet precautions for positive Covid-19. The findings included: The facility's policy entitled "Covid-19 Prevention, Response and Reporting" implemented 5/15/2023 and revised on 8/5/2023 indicated under #9 Source control measures: Source control options for HCP include:	F 880	1. The facility failed to implement their infection control policies for Covid-19 when Nurse #5 failed to change into full Personal Protective Equipment (PPE), to include changing out of her surgical mask and applying a N95 mask, prior to entering a room that was on enhanced droplet precautions for Covid-19. This observation occurred during an active outbreak of Covid-19 for 1of 2 resident rooms on enhanced droplet precautions for positive Covid-19. Nurse #5 was immediately reeducated on donning and doffing proper personal protective equipment when resident is on precautions and how to distinguish what needs to be worn by the staff development coordinator (SDC) on 9/11/23.	

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F 880	Continued From page 33 A NIOSH-approved particulate respirator with N95 filters or higher. A respirator approved under standards used in other countries that are like NIOSH-approved N95 filtering facepiece respirators. A barrier face covering that meets ASTM F302-21 requirements including Workplace Performance and Workplace Performance Plus masks. A well-fitting face mask. Source control can be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If source control is used during the care of a resident for which a NIOSH-approved particulate respirator or facemask is indicated for PPE, they should be removed and discarded after the resident care encounter and a new one donned. Source control is recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection. Upon entering the facility on 9/11/2023 there were 2 residents on the 500 hall with diagnoses of Covid-19, the residents were in room #507 and #509. Both residents had enhanced droplet precaution signs on the front of the door, that stated, "All Healthcare Personnel must:" Clean hands before entering and when leaving room.	F 880	2. Current facility residents are at risk to be affected by the deficient practice. The SDC began education with current facility and agency staff on 9/11/23 on donning and doffing proper personal protective equipment when resident is on precautions and how to distinguish what needs to be worn by the SDC. 3. The following measures have been put into place to ensure the deficient practice does not recur are as follows; current facility and agency staff will be educated on donning and doffing proper personal protective equipment when resident is on precautions and how to distinguish what needs to be worn by the staff development coordinator (SDC) and completed by 9/18/23. Newly hired facility and agency staff and facility and agency staff that did not complete education by 9/18/23, will complete education upon hire and prior to working their next shift. 4. The Director of Nursing or Staff Development Coordinator will complete random audits three (3) times a week for four (4) weeks, then two (2) times a week for 4 weeks, then weekly for 4 weeks to ensure compliance. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data from audits will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 34 Wear a gown when entering the room and remove before leaving the room. Wear N95 or higher-level respirator before entering the room and remove after exiting. Wear Protective eye wear (face shield or goggles). Wear gloves when entering room and remove before leaving. Place in a private room. Keep door closed (if safe to do so). An observation on 9/11/2023 at 10:40 AM revealed Nurse #1 applying PPE to include, gown, gloves, and a face shield. She was observed wearing a surgical mask, in the hall and prior to entering Resident #226's room. Nurse #1 did not apply an N95 mask prior to entering the room. An enhanced droplet precaution sign was on the outside of the door and a caddy containing PPE of gowns, gloves, N95 masks and face shields was available on the door. Nurse #1 entered room #507 and assisted Resident #226. When Nurse #1 exited the room, she had already removed her PPE and placed in a trash can provided in the room by the door. She kept on her surgical mask and continued down the hall to the nurses station. An interview was conducted with Nurse #5 on 9/11/2023 at 11:38 AM revealed she was aware that Resident #226 had an active diagnosis of Covid-19. She stated the resident had an enhanced droplet precaution sign on the front of the door. She stated she was in a hurry and did not remove her surgical mask prior to entering	F 880	be made to the plan as needed. 5. Completion Date: 9/18/23	

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F 880	Continued From page 35	F 880		

the room and apply a N95 as was instructed by the enhanced droplet precaution sign. Nurse #1 stated it was her mistake and she knew to apply the N95 mask before entering the room and she should have removed it and applied another mask when exiting the room. She stated she had been trained on infection control and prevention and knew she should wear full PPE, including an N95 mask when taking care of a Covid-19 patient.

An interview was conducted with Director of Nursing (DON)/Infection Preventionist on 9/11/2023 at 11:42 AM: He stated staff should have known to wear full PPE in Resident #226's room, to include changing out of the surgical mask and applying a N95 mask prior to entering Resident #226's room. He revealed Covid-19 positive residents each had an enhanced droplet precaution sign on their door and a caddy with PPE. The DON stated staff had instructions on the door that instructed staff on what PPE was needed to enter the room, this guidance included wearing a N95 mask or higher before entering a room with enhanced droplet precautions. The instructions included wear gown, gloves, eye protection and N95 mask prior to entering the room. He indicated he would re-educate staff regarding the use of PPE for residents with special droplet contact precautions. He stated that all staff are instructed on infection control on hire, annually and anytime there is a need. The DON stated he would re-educate Nurse #1 one on one.