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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/28/24 through 02/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XF6211.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/28/24 to conduct a recertification and complaint investigation survey and exited on 02/01/24. Additional information was obtained offsite on 02/02/24. Therefore, the exit date was changed to 02/02/24. Event ID # XF6211. The following intakes were investigated: NC00212458, NC00210164, NC00199743, NC00201606, NC00203458, NC00203435, NC00196712, NC00197422, NC00208174, NC00206009, NC00205218, NC00205221, NC00196635, NC00212147, NC00207822, NC00209291, NC00203605, NC0019906, NC00210166, and NC00194396. 7 of the 65 complaint allegations resulted in deficiency.	F 000		
F 551 SS=B	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those	F 551		2/29/24

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

Electronically Signed | 02/23/2024

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rights are delegated to the representative.
(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right

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F 551	Continued From page 2 to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with the Health Care Power of Attorney (HCPOA), the Resident Representative, staff, and the Medical Director, the facility failed to honor an immunization declination when Resident #376 was administered an influenza vaccine after her HCPOA had declined the vaccination. This was for 1 of 6 residents reviewed for vaccination status (Resident #376). The findings included: Resident #376 was admitted to the facility on 8/14/22. Review of Resident #376's medical record revealed The Statutory Form Health Care Power of Attorney dated 3/2/21. The form indicated Resident #376 appointed her Health Care Power of Attorney (HCPOA) to act for her and in her name to make health care decisions for her. It further indicated that Resident #376 granted her HCPOA full power and authority to make health care decisions on her behalf, including, but not limited to: to give consent for, to withdraw consent for, or to withhold consent for, x-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician,	F 551	F551 Rights Exercised by Representative: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #376 no longer resides in the facility. 2. How the facility will identify other residents potentially affected by the same deficient practice: Nurse management conducted a 100% audit of current residents for the Flu season 2023/2024 to verify that informed consent was obtained appropriately; For residents listed as their own responsible party with a BIMS of 9 or above, their own consent is accepted; For Residents with a BIMS of 8 or below, the resident's representative must be contacted to provide consent for the administration of the Flu vaccine. Audit was completed on 2/23/24.	

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F 551	Continued From page 3 dentist or podiatrist. The Informed Consent for Influenza Immunization for Resident #376 dated 8/14/22 indicated Resident #376's HCPOA marked the box for: having been educated on the benefits and risks associated with not receiving the influenza vaccine, (she) hereby declined permission for this facility to administer the vaccination. The form was signed by Resident #376's HCPOA and the Admissions Director on 8/14/22. A Palliative Care Nurse Practitioner note dated 9/20/22 for Resident #376 indicated Resident #376 had altered mental status. Resident #376 did not consistently answer questions asked. She was alert but did not appear to fully understand what was being asked of her. The significant change in status Minimum Data Set assessment dated 9/26/22 indicated Resident #376 was severely cognitively impaired. An Informed Consent for Influenza Immunization for Resident #376 dated 9/29/22 indicated the box was checked for: having been educated on the benefits and risks associated with receiving the influenza vaccine, (she) hereby give this facility permission to administer the vaccination, unless medically contraindicated. The form was signed by the Director of Nursing on 9/29/22 with a notation of: resident gave verbal consent. A nurses' progress note dated 10/13/22 at 8:37 PM by Nurse #3 in Resident #376's medical record indicated influenza vaccine was given this morning without any adverse reaction. Resident #376 denied any pain. Vital signs were within normal limits.	F 551	3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Staff Development coordinator and/or the Director of Nursing educated the licensed nursing staff on the facility's policy for administering the Flu vaccine. Education included that staff must verify that the resident is cognitively able to provide informed consent, or that consent will be obtained from their Representative before the Flu vaccine is administered. Education was completed on 2/23/24. Licensed staff will not be permitted to work until education is complete. Education will be verified by nurse management. Education to include agency staff. Any new hires will be educated on topic during orientation. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of Nursing and/or the Staff Developement Coordinator will audit Flu vaccine consent forms to verify that consent has been obtained by the appropriate party before the vaccine is administered. Audit will be conducted 5x per for 4 weeks; 3xper week for 4 weeks; Then 1x per week for 4 weeks. The Director of Nursing will report findings monthly to the Quality	

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F 551	Continued From page 4 A phone interview with Nurse #3 on 1/30/24 at 9:28 AM revealed Resident #376 received the influenza vaccine in the morning shift on 10/13/22. Nurse #3 stated he worked the evening shift on 10/13/22 and received report from the outgoing nurse that Resident #376 got the flu shot that morning. Nurse #3 could not remember Resident #376 or which nurse gave Resident #376 the flu shot but he remembered receiving a phone call from Resident #376's HCPOA on 10/13/22. Resident #376's HCPOA was upset about Resident #376 receiving a flu shot despite her signing the declination form as witnessed by the Admissions Director. Nurse #3 told Resident #376's HCPOA that he would get someone to follow-up with her. A phone interview with Resident #376's HCPOA on 1/30/24 at 8:40 AM revealed Resident #376 was admitted to the facility to receive comfort care due to a terminal illness. The HCPOA stated that she and Resident #376's Resident Representative visited Resident #376 every day while she was at the facility and Resident #376 was confused and not responding appropriately the whole time she was there. On 10/13/22 while the Resident Representative was at the bedside, a nurse administered the flu shot to Resident #376. The Resident Representative notified the HCPOA about this, so the HCPOA called the Director of Nursing (DON) and asked her why Resident #376 was given the flu shot when she did not consent to this. The HCPOA stated that the DON told her that they had assumed she consented to the flu vaccine because she had consented to the COVID-19 booster. The HCPOA further stated that Resident #376 had brain cancer, and should not have been given the	F 551	Assurance/Performance Improvement Committee for suggestions and/or recommendations until substantial compliance is achieved and maintained. 5. Compliance Date: February 29, 2024	

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flu vaccine which was not necessary and was not approved by her. The HCPOA reiterated that she had the right to make healthcare decisions for Resident #376 and that Resident #376 did not have the ability to give an informed consent to the flu vaccine.

A phone interview with the Resident Representative on 1/30/24 at 9:25 AM revealed she witnessed Nurse #2 administer a shot to Resident #376 on 10/13/22. The Resident Representative stated she asked Nurse #2 what it was, and Nurse #2 told her it was the flu vaccine. She further stated she did not observe Nurse #2 ask Resident #376 if she wanted to receive the flu shot before administering it to her. Nurse #2 also did not ask the Resident Representative if she was fine with Resident #376 receiving the flu shot. She also shared that Resident #376 was awake that day, but she was confused.

An interview with Nurse #2 on 1/30/24 at 9:54 AM revealed she did not remember Resident #376 but stated that it was possible that she had given Resident #376 her flu shot on 10/13/22. Nurse #2 stated she was sometimes asked to give flu immunizations and the DON would normally give her a list of residents who were supposed to receive the flu shot. Nurse #2 stated she did not look at the consents prior to administering the flu shots and assumed that the residents on the list had signed consent forms. Nurse #2 also stated that she later found out that Resident #376's HCPOA had declined for her to receive the flu vaccine.

An interview with the Admissions Director on 1/30/24 at 1:07 PM revealed she witnessed Resident #376's HCPOA decline the influenza

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immunization when she signed her paperwork during admission. The Admissions Director stated she had a copy of the paperwork regarding Resident #376's HCPOA which meant that Resident #376 had chosen her HCPOA to make medical decisions for her.

An interview with the Medical Director (MD) on 2/1/24 at 11:46 AM revealed Resident #376 had intermittent periods of confusion when he saw her on 9/29/22 but with Resident #376's medical diagnosis of brain tumor, it would be a bonus to get anything out of her cognitively and he wouldn't expect her to able to give an informed consent. The MD stated the staff probably should have consulted with the HCPOA regarding the immunization and hospice because they were more familiar with the resident.

An interview with the Director of Nursing (DON) on 2/1/24 at 8:44 AM revealed she could vaguely remember Resident #376 or having conversations with her HCPOA. The DON stated when residents were admitted to the facility, the family member would initially sign the paperwork which included the immunization consent/declination forms. The DON stated when Resident #376 was admitted, it was not flu season, so she obtained a verbal consent from Resident #376 on 9/29/22. The DON stated Resident #376 was probably alert that day and she would have asked her if she wanted to receive the flu shot or not. The DON stated she normally just told the residents that possible adverse reactions were flu-like symptoms and soreness on the injection area, but she did not usually ask them to repeat the information she provided regarding the flu shot. The DON stated she did not know that Resident #376's HCPOA

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had declined for her to receive the flu shot initially and did not look back at the consent/declination forms for Resident #376. The DON further stated that the Admissions Director should have written in the immunization consent forms that the flu shot was not in season to alert the HCPOA that they would be asked again during flu season. The DON added that she did not ask Resident #376's HCPOA again or friend at the bedside about whether Resident #376 should receive the flu shot because she obtained the verbal consent from Resident #376. The DON maintained that based on the nurses' progress notes in Resident #376's medical record, she had been alert but the DON was not aware that Resident #376 had been assessed as severely cognitively impaired. The DON stated that they would call the responsible party to obtain consent for severely cognitively impaired residents. She also shared that she vaguely remembered receiving a phone call from Resident #376's HCPOA who questioned her why Resident #376 received a flu vaccine despite her having declined to it.

An interview with the Administrator on 2/1/24 at 12:41 PM revealed he did not remember Resident #376 and did not remember the issue with her receiving the flu vaccine even though her HCPOA declined for her to receive it. The Administrator stated they would usually obtain consent from the resident or the family member prior to administering immunizations. If the resident was able to give consent and make their own decisions, they would ask the resident. The Administrator stated that residents who had moderate cognitive impairment and intact cognition would be able to give their consent to immunizations.

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F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and physician, the facility failed to protect residents' rights to be free from misappropriation of controlled medication for 5 of 5 residents (Resident #40, #126, #128, #129, and #130) reviewed for misappropriation of resident property. The findings included: The facility's Abuse Prevention, Intervention, Reporting, and Investigation policy, last revised February 2021, revealed in part the facility would ensure all residents were free from misappropriation of property. A review of the initial allegation report dated 12/10/22 revealed the facility became aware of the incident on 12/10/22 at 8:30 AM when 5 tablets of Ativan (medication used to treat anxiety) for Resident #128 and 6 tablets of oxycodone (pain medication) for Resident #129 were reported missing. All the Residents were in the facility when the incident occurred on 12/10/22. Residents #126,	F 602	Past noncompliance: no plan of correction required.	

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#128, #129, and #130 had been discharged from the facility when the surveyor started the investigation on 01/28/24.

The 5-day investigation report dated 12/16/22 revealed during the facility's investigation, additional medications that were prescribed to Resident #40, Resident #126, and Resident #129 were unaccounted for. The allegation of diversion of Residents' drugs was substantiated and Nurse #1 was terminated on 12/15/22.

During an interview conducted with Nurse Aide (NA) #1 on 01/29/24 at 3:09 PM, she stated while she was working on the 400 hall on 12/09/22, she saw Nurse #1 putting 2 cards of controlled medications into her personal bag in the 400 Hall charting room around 7:15 PM. She added Nurse #1 was aware that she had witnessed the incident; however, they did not talk to each other at that moment. She was shocked to see the incident and immediately notified the DON via text message. The DON wanted to know which medications were stolen and she replied, Ativan and oxycodone and the DON told her that she would handle the case. She stated when she approached Nurse #1 around 6:00 AM as one resident was asking for pain medication, Nurse #1 was sleeping and acting weird and upon waking up. NA #1 left the facility after completing her shift on 12/10/22 morning around 6:45 AM.

An interview was conducted with the DON on 01/29/24 at 3:50 PM. She stated she was at home when NA #1 reported the incident during the evening on 12/09/22. She called the local law enforcement agency immediately, and the police came to the facility to take a statement from Nurse #1. When she came into the facility the

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next morning, Nurse #1 had already left the facility. She called Nurse #1 on the morning of 12/10/22 and informed her that she was suspended for 5 days pending an investigation of potential drug diversion. During the investigation, she confirmed Nurse #1 had handled the returning totes (a plastic cage contained medications to be returned to the pharmacy) in medication storage room on 12/09/22 evening and 5 tablets of Ativan 0.5 milligrams (mg) for Resident #128 and 6 tablets of oxycodone 5 mg for Residents #129 were reported missing. On 12/11/22 morning, the Assistant Director of Nursing (ADON) reported seeing torn count sheets in the sharp container in a medication cart. She instructed the ADON to put the sharp container in the medication storage room and she would investigate the next morning. When she pieced the torn sheets back together on 12/12/22 morning, she found that 2 tablets of Norco (a pain medication containing hydrocodone and Tylenol) 5/325 mg for Resident #130, 6 tablets of Norco 5/325 mg for Resident #126, and 6 tablets of oxycodone 10 mg for Resident #40 were missing. The DON stated all the Residents affected by the incident were assessed immediately without any adverse effects noted. She notified the Board of Nursing and DEA on 12/12/22, and the Medical Director on 12/14/22. She started the in-service to educate all the licensed nurses on 12/12/22 and it was completed by 12/19/22. She stated Nurse #1 was terminated on 12/15/22 and all the missing controlled medications were replaced at the cost of the facility. The families of the Residents involved in the incident were notified on 12/16/22.

An attempt to conduct a phone interview with Nurse #1 on 01/31/24 at 4:11 PM was

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unsuccessful. She did not return the call.

During an interview conducted on 02/01/24 at 12:42 PM, the Medical Director (MD) stated he was informed on 12/14/2022 of the missing controlled substances and the list of Residents affected. He stated all the affected Residents were assessed immediately without any adverse consequences noted as the missing drugs were used on "as needed" basis. He added all the missing medications were replaced and paid for by the facility.

The facility provided the following corrective action plan with a completion date of 12/20/22:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

CNA #1 reported to Director of Nursing on 12/10/2022 Licensed Nurse (Nurse #1) had potentially taken PRN (as needed) controlled substances from two resident PRN-controlled substance cards. No negative outcomes for the 2 residents as they were PRN medication and facility had the controlled substances in backup. Medication was replaced prior to residents requesting them.

Director of Nursing suspended the Licensed Nurse (Nurse #1) who was suspected of misappropriation during the investigation immediately on 12/10/2022 upon learning of the incident. Director of Nursing completed the 24-hour report to the Department of Health and Human Services (DHHS) on 12/10/2022. The Director of Nursing then began an investigation of missing controlled substances and completed

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interviews with all licensed nurses who had worked on the cart of missing controlled substances. Director of Nursing submitted the five-day report upon completion of investigation on 12/16/2022 to DHHS.

The facility Director of Nursing Notified the Board of Nursing on 12/12/2022, the DEA was notified on 12/12/2022, and the local Police Department on 12/10/2022 upon the discovery of the missing controlled substances.

Facility notified the Medical Director on 12/14/2022 of the missing PRN controlled substances and the residents involved. Residents were assessed on 12/10/2022 with no adverse effects as the medications were PRN and replaced by facility prior to being needed.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

100% Audit was conducted 12/10/2022 by the Director of Nursing and Charge Nurses of the control sheets and each medication on all medication carts to verify that all controlled substances and control sheets and discovered all PRN-controlled substances were not accounted for.
The Director of Nursing found that there was a total of 5 affected residents following the audit. The facility replaced all medications as required for missing medications. Facility replaced all missing medication as of 12/14/2022.

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

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Education was provided in person for all licensed nursing staff by the Director of Nursing on the pharmacy policy related to maintaining controlled medications and narcotics on the medication carts and signing of shift-to-shift count sheets and was completed by 12/19/22. Education also included counting and verifying the count is correct education to be completed by 12/19/2022. Also included in the education the nurses will document the number of sheets in the narcotic and controlled medications count book for the number of medication packages are located in the locked medication cart. If a medication is discontinued the nurse will remove the card and the medication record and document the number of cards and the sheets that remain on the cart. The nurse will give the removed sheet to the DON to maintain, the sheets will be placed under the Director of Nursing office door if he/she is not available or out of facility. Two nurses will return the discontinued meds to the pharmacy and two nurses will sign and verify. The medications will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurses will give a copy of the record and a copy of the returned to pharmacy sheet to the DON to maintain in a file cabinet in her office. Two nurses will complete a shift-to-shift count to verify that the number listed on the controlled medications record matches the amount of medication in the cart and verify that the numbers of sheets are correct. Staff will not be permitted to work until education is completed, including agency staff. Education will be a part of orientation for all new hires and agency licensed staff prior to working their first shift.

The Director of Nursing will continue to maintain

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file folders for controlled medications in the facility for receiving and returning controlled medications. The Director of Nursing will verify controlled medications count of delivery manifest sheets received from the pharmacy. Manifest sheets will be maintained by the month received as of 12/19/2022. The facility will follow the facility's policy in maintaining control medications. The licensed nurses will receive and document receiving the controlled medication from pharmacy. The nurses will document the number of sheets in the narcotic count book for the number of medication packages are located in the locked med cart. If a medication is discontinued the nurse will remove the card and the medication record and document the number of cards and the sheets that remain on the cart. The nurse will give the removed sheet to the DON to maintain, the sheets will be placed under the Director of Nursing office door if he/she is not available or out of facility. Two nurses will return the discontinued meds to the pharmacy and two nurses will sign and verify. The medications will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurses will give a copy of the record and a copy of the returned to pharmacy sheet to the DON to maintain in a file cabinet in her office. Two nurses will complete a shift-to-shift count to verify that the number listed on the controlled medications record matches the amount of medication in the cart and verify that the numbers of sheets are correct.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Nursing and/or Designee will audit

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medication carts related to narcotic count being correct and the medication cards matches the control sheets, and the shift-to-shift count sheet are being signed at the start and at the end of the shift. Auditing will be completed 5 times Per week for 4 weeks then weekly for 4 weeks. The Director of Nursing will report all findings of audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months for any needed improvement.

The facility completed Ad Hoc QAPI to review the investigation and current action plan to ensure all components were done and followed on 12/19/2022.

Compliance Date: 12/20/2022.

The facility's corrective action plan with a correction date of 12/20/22 was validated onsite by observations and interviews with the DON and nursing staff.

An observation was conducted during a shift transition for a medication cart between 2 nurses. Nurses started with counting the total number of blister cards that contained controlled medication in the medication cart and verified the balance in the count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the narcotic sheet was consistent with the actual counts. After all the counts were completed without any issues, the incoming nurse signed the controlled medication count sheet before the outgoing nurse passed the medication cart key to her.

Medication Administration observations were conducted on 01/30/24 and it consisted of 25

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F 602	Continued From page 16 medications, 5 different residents, and 4 Nurses. There was one medication error identified but it was not related to misappropriation of medications. Nursing staff confirmed they had received in-service training regarding pharmacy policy on safeguarding of controlled medications in medication carts, signing of shift-to-shift count sheets, tracking of total number of sheets of controlled medications in the locked medication cart with the count sheet, and proper procedures of returning discontinued controlled medications to the pharmacy. Nursing staff were assigned to review the policy related to proper handling and storage of all controlled substances prior to the training. The training was conducted in-person by DON, and it included multiple examples and scenarios. Interview with the DON revealed she launched an in-service immediately after the incident to re-educate all the licensed nurses and to introduce a new tracking system for receiving of new additional controlled medication cards and removal of expired or empty cards. She audited the medication cart randomly to ensure all controlled medication counts were conducted appropriately and the count sheets were documented properly. She stated the interventions were successful as the facility did not have any similar diversion issues since then.	F 602		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		2/29/24

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reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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F 636	Continued From page 18 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAAs) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 5 sampled residents (Residents #30 and #58). The findings included: 1a. Resident #30 was admitted to the facility on 02/01/23 with diagnoses including depression. A review of the most recent admission Minimum Data Set (MDS) dated 02/07/23 revealed Resident #30 was coded with intact cognition. A review of Section V which consisted of care area assessment summary indicated the care area for psychotropic drug use was triggered for Resident #30. Other than checking a list of psychotropic drugs received by Resident #30 and the adverse consequences of using the psychotropic drugs,	F 636	F636 Comprehensive Assessments & Timing: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Additional comprehensive assessment for resident #30 was completed by Minimum Data Set (MDS) Coordinator with ARD of 2/7/24, with appropriately completed Care Area Assessments (CAA). Resident #58 is no longer a resident of the facility. 2. How the facility will identify other residents potentially affected by the same deficient practice:	

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F 636	Continued From page 19 the facility did not provide any information in analysis of findings that described the nature of Resident 30's problems, possible causes and contributing factors, risk factors related to the care area, and reasons to proceed with care planning. A further review of the above admission MDS revealed a total of 11 care areas were triggered. 7 out of the 11 triggered areas for CAAs in Section V which included activities of daily living functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer, psychotropic drug use, and pain were submitted without any pertinent information in analysis of findings. 1b. Resident #58 was admitted to the facility on 07/17/23 with diagnoses including congested heart failure. A review of the most recent admission MDS dated 07/23/23 revealed Resident #58 was coded with severely impaired cognition. A review of Section V indicated the care area for urinary incontinence and indwelling catheter was triggered for Resident #58. Other than indicating Resident #58 was diagnosed with congested heart failure and receiving diuretic and antipsychotic medications, the facility did not provide any information in analysis of findings that described the nature of Resident 30's problems, possible causes and contributing factors, risk factors related to the care area, and reasons to proceed with care planning. A further review of the above admission MDS revealed a total of 8 care areas were triggered. All the 8 triggered areas for CAAs in Section V	F 636	A 100% audit was completed by the Regional MDS Nurse 2/22/2024 for all active residents that had a comprehensive in the last 60 days to ensure all CAA's were addressed in the analysis of findings. No further issues were found. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: As an MDS is completed, a CAA is triggered based off of MDS coding for that specific resident. A CAA assessment will then be completed by the MDS coordinator to address the reason a CAA triggered. The Regional MDS Nurse completed education with facility MDS nurse on 2/2/2024 regarding appropriate completion of CAA's. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Regional MDS nurse will review 3 random comprehensive assessments weekly for 4 weeks, then every other week (bi-weekly) for 3 months to ensure CAAs are being addressed appropriately in the analysis of findings. The MDS Nurse, Director of Nursing (DON), Regional MDS Nurse, and Unit Manager will complete a summary of audit findings for the Quality Assurance/Performance Improvement	

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F 636	Continued From page 20 which included cognitive loss/dementia, activities of daily living functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use were submitted without any pertinent information in analysis of findings. During an interview conducted on 01/30/24 at 1:42 PM, the MDS Coordinator confirmed 7 of the 11 triggered care areas for Resident #30's MDS dated 02/07/23 and all the 8 triggered care areas for Resident #58's MDS dated 07/23/23 were submitted without any pertinent information in analysis of findings in Section V. She explained she started her role about 3 weeks ago and was unable to explain how it happened. She acknowledged that it was an error to submit an admission MDS without the completion of analysis of findings for all the triggered areas. An interview was conducted with the Regional MDS Coordinator on 01/30/24 at 1:47 PM. She stated Section V for Resident #30's MDS dated 02/07/23 and Resident #58's MDS dated 07/23/23 were submitted by the former MDS Coordinator without completion of analysis of findings. She could not explain how it happened and acknowledged that it was an error. On 01/31/24 at 3:35 PM an interview was conducted with the Director of Nursing. She stated all the CAAs must be individualized and completed comprehensively. It was her expectation for the MDS Coordinator to complete the analysis of findings for all the triggered areas in Section V before submission.	F 636	(QAPI) committee for any needed improvement. The QAPI committee will review monthly and make any necessary recommendations immediately until substantial compliance is achieved and maintained. 5. Compliance Date: February 29, 2024	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g)	F 641		2/29/24

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F 641	Continued From page 21 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the area of falls for 1 of 5 residents reviewed for Resident Assessments (Resident #51). Findings included: Resident #51 was admitted to the facility on 06/03/22 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or loss of strength on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, dementia without behavioral disturbance, and anxiety. Review of the facility's incident log for January 2023 to March 2023 revealed Resident #51 had the following documented falls: On 02/03/23 she was observed on the floor of her room with no apparent injuries upon assessment. On 02/20/23 she was observed on the floor of her room with no apparent injuries upon assessment. On 03/03/23 she was observed on the floor of her room with no apparent injuries upon assessment. The quarterly MDS assessment dated 03/17/23 assessed Resident #51 with severe cognitive impairment. She required partial/moderate assistance with moving from a lying position on the bed to sitting on the side of the bed with feet flat on the floor and walking was not attempted	F 641	F641 Accuracy of Assessments: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Assessments with Assessment Reference Date (ARD) of 3/17/23 and 4/24/23 for residents #51 have been modified and were transmitted 2/22/2024 to accurately reflect coding of falls. 2. How the facility will identify other residents potentially affected by the same deficient practice: A 100% audit was conducted by The Regional Minimum Data Set (MDS) Nurse on 2/22/2024 for all active residents to ensure that any falls in the last 60 days were appropriately recorded on the MDS. No further issues were found. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: When a fall occurs, the fall will be recorded on the next assessment as fall without injury, fall with injury not major, or fall with major injury in section J of the	

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F 641	Continued From page 22 due to medical condition or safety concerns. Resident #51 had no falls since the previous MDS assessment which was coded as a quarterly and dated 01/20/23. Review of the facility's incident log for March 2023 to April 2023 revealed Resident #51 had the following documented fall: On 03/23/23 she was observed on the floor in the hallway with no apparent injuries upon assessment. The quarterly MDS assessment dated 04/24/23 assessed Resident #51 with severe cognitive impairment. She required partial/moderate assistance with moving from a lying position on the bed to sitting on the side of the bed with feet flat on the floor and walking was not attempted due to medical condition or safety concerns. Resident #51 had no falls since the previous MDS assessment which was coded as a quarterly and dated 03/17/23. During an interview on 02/01/24 at 10:35 AM, the MDS Coordinator revealed the previous MDS Coordinator left employment prior to her starting in January 2024 and she was still trying to get assessments caught up that had not been done. She confirmed that Resident #51's falls were missed by the previous MDS Coordinator and were not captured on the corresponding MDS assessments. The MDS Coordinator stated the MDS assessment dated 03/17/23 should have indicated Resident #51 had 3 falls with no injury and the MDS assessment dated 04/24/23 should have indicated Resident #51 had one fall with no injury. During a joint interview on 02/01/24 at 4:10 PM,	F 641	MDS. The Regional MDS nurse completed education with the facility MDS Coordinator on 2/2/2024 regarding accurate coding of falls on the MDS. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Regional MDS nurse will review 3 random assessments weekly for 4 weeks then every other week (bi-weekly) for 3 months to ensure all falls are accurately coded on the MDS. The MDS Nurse, Director of Nursing (DON), Regional MDS Nurse, and/or Unit Manager will report findings to the Quality Assurance/Performance Improvement (QAPI) committee for any needed improvement. The QAPI committee will review monthly and make any necessary recommendations immediately until substantial compliance is achieved and maintained. 5. Compliance Date: February 29, 2024	

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F 641	Continued From page 23 both the Director of Nursing and Administrator stated they expected for MDS assessments to be completed accurately. During an interview on 02/01/24 at 4:13 PM, the Regional MDS Consultant explained they had previously identified issues with MDS inaccuracy specific to the coding of antiplatelet and hypoglycemic medications and had developed a Performance Improvement Plan (PIP) to address the issue. The Regional MDS Consultant stated she was unaware of the MDS inaccuracy specific to the coding of falls until it was recently brought to her attention.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with the Family Member, Medical Doctor, and staff, the facility failed to obtain a physician's order and initiate wound care treatments and failed to document characteristics including the location, size, and type of wound upon first observation of an existing venous ulcer for 1 of 1 resident reviewed for professional standards (Resident #30).	F 684	F684 Quality of Care: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: For resident #30, treatment was initiated on 7/25/23 for a venous ulcer to the right shin and discontinued on 7/31/	2/29/24

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F 684	Continued From page 24 Findings included: Resident #30 was admitted to the facility on 02/01/23 with the current diagnoses including diabetes mellitus, hypertension, and chronic respiratory failure. The skin assessments for Resident #30 revealed on 07/15/23 the skin was intact and on 07/22/23 the skin was not intact. Both assessments were completed by the Wound Care Nurse. The skin assessment dated 07/22/23 did not provide information including a description, size, or location of the skin that was not intact. Review of the nurse progress notes revealed no documentation Resident #30's skin was not intact, or treatment was provided on 07/22/23 through 07/24/23. During an interview on 01/28/24 at 2:49 PM Resident #30 stated several months ago his Family Member noticed an open sore on his leg and complained there was no bandage. Resident #30 denied any current open wounds or blisters on his lower legs and stated after the Family Member complained, the Wound Care Nurse consistently checked his legs and applied a cream for dry skin. An interview was conducted on 01/31/24 at 10:37 AM with the Family Member of Resident #30. The Family Member stated she visited Resident #30 on 07/23/23 and described his legs were huge, edematous (excess fluid trapped in body tissue), weeping, and oozing serosanguinous fluid (thin, watery fluid secreted from a wound) and she was concerned for risk of an infection if left open. The Family Member stated Resident #30 was wearing	F 684	23 once wound healed. Nurses #6 and #7 were educated on the facility policy for managing wounds in the facility. Education included: that they must complete a weekly skin check on each resident, if skin is not intact, document in resident□s progress notes a description of the wound. Include location, size, and if any drainage is noted. Place a call to the Nurse Practitioner (NP) or the Physician immediately to obtain a treatment order. Notify the resident and/or responsible party of new skin area and treatment. Education was provided by the Director of Nursing and completed by 2/23/24. 2. How the facility will identify other residents potentially affected by the same deficient practice: Skin checks were completed by the licensed nurses on all current residents to verify that skin is intact. For any new areas identified, the Nurse Practitioner or Physician was notified, and a treatment order was obtained. Audit was completed by 2/23/24. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing and/or the Staff development Coordinator educated the nursing staff on the facility□s policy on wound management. Certified nursing	

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F 684	Continued From page 25 shorts and the wound was visible to her from the hall as she entered the room. She revealed Resident #30 had a history of venous ulcer wounds and it was important he get wound care. The Family Member stated after speaking with Nurse #6 the nurse did not know about the area and had no Medical Doctor (MD) orders for treatment. During an interview on 01/31/24 at 7:32 PM Nurse #6 recalled the incident when the Family Member was upset about a wound on Resident #30's leg with no bandage. Nurse #6 stated she told the Family Member she was not aware of the wound and there were no treatment orders or documentation of any wound. She asked Nurse #7 for help and to assess Resident #30's leg and to apply a dressing. Nurse #6 stated a temporary treatment for wound care would be added to Resident #30's Treatment Administration Record (TAR) but she did not because she did not see the wound or provide the treatment Nurse #7 did. During an interview on 01/31/24 at 7:54 PM Nurse #7 recalled the Family Member of Resident #30 was upset about a wound on his leg with no bandage. Nurse #7 stated what she observed on the lower leg of Resident #30 was a blister that was draining fluid and appeared as a blister caused by edema (swelling caused by retention of fluid), but she was not sure if the blister had opened. Nurse #7 stated wound care protocol for a blister was to provide general first aid meaning to clean the area and apply a clean and dry dressing and notify the MD. Nurse #7 stated a communication book was used to notify the MD and if there was a wound, she would obtain orders and notify the Wound Care Nurse. Nurse #7 stated she did not recall if she provided wound	F 684	assistants must observe changes in the resident□s skin during showers or ADL care (Activities of Daily Living), and report to the licensed nurse immediately. Licensed nurses are to complete a weekly skin check on each resident, if skin is not intact, document in the resident□s progress notes a description of the wound. Include location, size, and if any drainage is noted. Place a call to the NP or the physician immediately to obtain a treatment order. Provide treatment as ordered and document. Notify the resident and/ or the responsible party of new skin area and treatment. Nurse management will review completion of weekly skin checks during daily clinical meeting 5 times per week Monday through Friday and verify that a treatment has been initiated for skin that is not intact. Education was completed on 2/23/24. Staff will not be permitted to work until education is completed. Education will be verified by nurse management. Education to include agency staff. Any new hires will be educated on topic during orientation. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of nursing and/or nurse management will audit completion of weekly skin checks, if it is documented that skin is not intact, a description of the wound will be documented in the	

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F 684	Continued From page 26 care for Resident #30 on 07/23/23 but did relay what she saw to Nurse #6 assigned to care for Resident #30 and returned to her assignment. Review of the physician orders revealed treatment for a venous ulcer on the right shin with a start date 07/25/23 provided directions to clean with normal saline, apply silver alginate, and cover with a foam dressing on Monday, Wednesday, and Friday. Review of the July 2023 TAR revealed there were no treatments for a blister or venous ulcer started on 07/22/23. A treatment for a venous ulcer on the right shin ordered on 07/25/23 was initialed by the Wound Care Nurse to indicate treatments were done Monday, Wednesday, and Friday. Review of the Wound Assessment for Resident #30 dated 07/27/23 identified the type of wound as a venous ulcer located on right lateral shin. The ulcer measured 5.50 centimeters (cm) in length, 3 cm in width, and 0.10 cm in depth with a moderate amount of serous drainage (clear, watery drainage from a wound). The wound assessment was documented by the Wound Care Nurse. The quarterly Minimum Data Set dated 11/14/23 indicated Resident #30 was cognitively intact with no unhealed pressure, venous, or arterial ulcers. Resident #30's comprehensive care plan revised on 01/24/24 identified skin alteration as a problem related to cellulitis (bacterial infection of the skin) and history of a septic knee. Interventions included assess skin daily with routine care, assess wound healing weekly, and provide treatment as ordered by the physician.	F 684	resident□s progress notes, the physician notified, and a treatment order obtained. Audit will be conducted 5x per week for 4 weeks, then 3xper week for 4 weeks, then 1x per for 4 weeks. The Director of nursing will report the results of findings monthly to the Quality Assurance/Performance Improvement (QAPI) Committee for suggestions and/or recommendations until substantial compliance is achieved and maintained. 5. Compliance Date: February 29, 2024	

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F 684	Continued From page 27	F 684		

During a telephone interview on 01/31/24 at 9:22 AM the Wound Care Nurse recalled the Family Member of Resident #30 was upset about an open wound on the lower leg with no bandage. The Wound Care Nurse stated a note was left for her check Resident #30 on Monday (07/24/23) which she did. She described what she saw appeared as a blister on the lower leg that had popped and was weeping and stated it was a significant venous ulcer. The Wound Care Nurse revealed the Nurse Practitioner saw the wound and provided the treatment order and now the ulcer was healed.

An observation of Resident #30's lower extremities on 01/31/24 at 9:29 AM revealed stretchable stockings were placed on both lower legs. The stockings were removed by the Wound Care Nurse and revealed no unhealed venous ulcers or blisters.

During a follow-up telephone interview on 02/01/24 at 3:00 PM the Wound Care Nurse stated she worked Monday through Friday and was not the person that completed the skin assessment on 07/22/23 (Sunday) and was unsure why her name was on the assessment.

During an interview on 02/01/24 at 12:01 PM the MD revealed he was familiar with Resident #30's history of lower extremity edema. The MD stated if the skin assessment on 07/22/23 identified the skin was not intact and there was no treatment order in place the nurse should call the MD provider and obtain orders and initiate in the resident's medical record (TAR) to ensure the wound treatments were consistently done.

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F 684	Continued From page 28 During an interview on 02/01/24 at 12:47 PM the Administrator stated he would want the nurse to follow the facility's policy related to wound care. An interview was conducted on 02/01/24 at 1:03 PM with the Director of Nursing (DON). The DON stated if the wound was open and weeping, she would expect the nurse to initiate standing orders in Resident #30's medical record on the TAR to ensure a clean and dry dressing was applied until the area could be assessed by the Wound Care Nurse for her to obtain MD orders for the treatment of the venous ulcer.	F 684		
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 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.	F 756		2/29/24

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F 756	Continued From page 29 (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 Medical Director (MD), the Consultant Pharmacist failed to provide recommendations when the facility failed to transcribe four physician orders for a scheduled opioid pain medication to the medication administration record (MAR) from 11/06/23 through 12/21/23 and ensure there was a current order on the MAR to administer the pain medication for 1 of 5 residents reviewed for unnecessary medications (Residents #30). The findings included: Resident #30 was admitted to the facility on 02/01/23 with diagnoses including osteoarthritis. A review of Resident #30's care plan for pain dated 11/03/23 revealed he was at risk of pain due to osteoarthritis. The goal was to decrease the frequency and intensity of pain. Interventions included administering pain medications as	F 756	F756 Drug Regimen Review, Report Irregular, Act On: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #30's oxycodone was transcribed on the resident's medication administration record, and is being administered as ordered as of 1/19/2024. The Consultant pharmacist was educated by the Clinical Director of Pharmacy to identify the drug irregularities related to expired order, and report findings to the facility in a timely manner when performing the monthly Medication Regimen Review (MRR). Education was completed on 1/31/24.	

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F 756	Continued From page 30 ordered. A review of the physician's order dated 11/03/23 indicated Resident #30 had an order to receive 1 tablet of oxycodone 10 milligrams (mg) by mouth once every 6 hours for pain for 14 days. This order expired after 14 days on 11/16/23. A review of the MAR for the months of November 2023 and December 2023 revealed Resident #30 continued to receive 10 mg of oxycodone 4 times daily until 12/26/23 with the expired order initiated on 11/03/23. Further review of Resident #30's physicians orders revealed four orders for oxycodone that were not transcribed to the MAR. 11/06/23 - Oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain. 11/21/23 - Oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain. 12/11/23 - Oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain. 12/21/23 - Oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain. The quarterly Minimum Data Set (MDS) dated 11/14/23 assessed Resident #30 with intact cognition and revealed he had received opioid each day of the 7-day assessment periods. A review of medical records indicated the Consultant Pharmacist had conducted monthly medication regimen reviews (MRRs) for Resident #30 on 12/08/23 and 01/11/24. There was no documentation regarding the orders for oxycodone written on 11/06/23, 11/21/23, 12/11/23, and 12/21/23 not being transcribed to	F 756	2. How the facility will identify other residents potentially affected by the same deficient practice: The Director of Nursing completed a 100% audit to verify that residents receiving oxycodone did not continue to receive the medication after the stop date. No other irregularities were identified. Audit was completed on 2/19/24. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing and/or the Staff Development Coordinator educated the licensed nurses on the process for transcribing physician orders. Education included: Verify stop dates and place the stop date on the medication administration record; Contact the Nurse Practitioner and/or the Physician to verify and obtain a new order if there is a need for the medication to continue; Do not give medication beyond the stop date; Must have a new order and transcribe with new date. Nurse management will review physician orders daily, during facility clinical meeting to verify that medications are transcribed and placed on the residents Medication Administration Record (MAR) as ordered, and that stop dates are verified, and to verify that stop dates are not exceeded.	

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F 756	Continued From page 31 the MAR or the order for oxycodone written on 11/03/23 expiring on 11/16/23. During an interview conducted on 01/28/24 at 2:15 PM, Resident #30 confirmed he had received 10 mg of oxycodone four times daily as ordered from 11/03/23 through 12/26/23. During a phone interview conducted on 01/30/24 at 11:18 AM, Nurse #5 acknowledged that she had transcribed the scheduled oxycodone order into the computer system when Resident #30 re-admitted to the facility from hospital on 11/03/23. She could not recall transcribing any other scheduled oxycodone orders for Resident #30 from 11/04/23 through 12/26/23. A phone interview was conducted with the Family Nurse Practitioner (FNP) on 01/30/24 at 3:28 PM. She confirmed the physician had issued 4 new orders of scheduled oxycodone for Resident #30 from 11/03/23 through 12/26/23. She did not know why these orders were not being transcribed into the MAR. During a phone interview conducted with the Consultant Pharmacist on 01/31/24 at 3:08 PM, she acknowledged that she had conducted MRRs for Resident #30 on 12/08/23 and 01/11/24. She did not notice that the oxycodone order written on 11/03/23 had expired after 11/16/23. She attributed the incident as an oversight. An interview was conducted with the Director of Nursing (DON) on 01/31/24 at 3:35 PM. She expected the Consultant pharmacist to identify the drug irregularities related to expired order and report the findings to the facility in a timely manner when performing the monthly MRR.	F 756	The Director of Nursing will review the consultant pharmacist monthly review for any transcription errors. Education of licensed nurses was completed on 2/23/24 by the Staff Development Coordinator. Staff will not be permitted to work until education is complete. Nurse management will verify completion, including agency staff. New hires will be educated on topic during orientation. 4. How the facility will monitor its performance to ensure the deficient practice does not recur: Nurse management will audit physician orders, to identify any transcription errors. Audits will be completed 5x per week for 4 weeks, then 3x per week for 4 weeks, then 1x per week for 4 weeks. The Director of nursing will review pharmacy recommendations monthly x3 months for identified irregularities. The Director of Nursing will report findings monthly to the Quality Assurance/Performance Improvement Committee for suggestions and/or recommendations until substantial compliance is achieved and maintained. 5. Compliance Date: February 29, 2024	

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F 756	Continued From page 32 During an interview conducted on 02/01/24 at 12:42 PM with the MD, he stated it was his expectation for the Consultant Pharmacist to identify the drug irregularities related to expired order and report the findings to him and the facility in a timely manner. During a phone interview conducted on 02/02/24 at 12:17 PM, the Clinical Services Director stated the physician had issued four new prescriptions of scheduled oxycodone for Resident #30 on 11/06/23, 11/21/23, 12/11/23, and 12/21/23. She added when the Consultant Pharmacist performed monthly MRRs for Resident #30, she had full access to the MAR and was expected to notice the scheduled oxycodone order initiated on 11/03/23 had expired by 11/16/23 and subsequent orders of scheduled oxycodone were not transcribed. It was her expectation for the Consultant Pharmacist to identify the errors and notify the facility in a timely manner.	F 756		
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.	F 812		2/29/24

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F 812	Continued From page 33 (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 and staff interviews the facility failed to cover, label, and date open food items in 1 of 1 walk-in cooler; discard potentially hazardous food from 1 of 1 walk-in cooler; label and date food stored in 1 of 1 kitchen; indicate the expiration date of thawed milkshakes and label and date food and beverage items in 2 of 2 nourishment room refrigerators and freezers (100/200 Hall and 400 Hall); and maintain clean refrigerator and freezers in 2 of 2 nourishment rooms (100/200 Hall and 400 Hall). These practices had the potential to affect food and drink items served to residents. Findings included: 1. An initial tour of the walk-in cooler on 01/28/24 at 10:31 AM revealed the following: (a). a re-sealable plastic bag of sliced tomatoes with no date (b). a metal pan containing pureed bread with no date (c). a box of apple pie open to air with no open date (d). an opened and undated container of chicken salad (e). a bag of sliced onions with a use by date of 01/27/24 2. An observation of the kitchen on 01/28/23 at	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were named in this alleged deficient practice. On 1/28/2024 all expired and undated food was removed from the dry storage room and refrigerators by the Dietary manager. All nourishment rooms have been cleaned and outdated foods removed by the Dietary Manager as of 1/28/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: As of 2/21/2024, the Dietary Manager completed an audit of all food storage areas to include dry storage, coolers, nourishment rooms and freezers, to ensure there was no outdated or unlabeled food. Any undated or expired food was removed during the audit. 3. Address what measures will be put	

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F 812	Continued From page 34 10:42 AM revealed a bin of sugar and a bin of flour were stored under a counter and were not labeled or dated. 3. An observation of the 100/200 Hall nourishment room on 01/28/24 at 10:50 AM revealed the following: (a). the refrigerator contained 2 thawed milkshakes sitting on a shelf. The manufacturer's instructions stamped on each carton of milkshake indicated the product was good for 14 days after being thawed. Neither of the milkshakes had a date indicating when they were placed in the refrigerator or when they expired. (b). multiple areas of dried debris to the shelves and inside door of the refrigerator (c). three opened and undated pints of ice cream, an opened and undated half-gallon of ice cream, an opened and undated gallon of ice cream, and an opened and undated 16.9-ounce bottle of soda in the freezer (d). multiple areas of dried debris inside the freezer 4. An observation of the 400 Hall nourishment room on 01/28/24 at 11:00 AM revealed the following: (a). an opened and undated container of nectar thickened water with lemon sitting on a shelf in the refrigerator (b). multiple areas of dried debris to the freezer An interview with the Dietary Manager on 01/30/24 at 8:24 AM revealed food items should be labeled and dated by the person who placed item in the cooler and dietary staff should be checking the walk-in cooler for expired food items	F 812	into place or systemic changes made to ensure that the deficient practice will not recur: As of 2/24/2024 Dietary Manager re-educated all dietary staff on facility policy for food procurement to include labeling and dating food when opened and discarding all foods by expiration date. Staff will not be permitted to work until education is complete. The dietary manager will verify education. New hires will be educated on the topic during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator and/or Designee will monitor food storage areas 5 times per week for 4 weeks, then 3 times per week for 4 weeks, and then weekly for 4 weeks to ensure all food items are stored and dated properly. The Dietary Manager will report all findings monthly to the Quality Assurance/Performance Improvement (QAPI) Committee for any needed changes or improvements. The QAPI Committee will review findings until substantial compliance is achieved and maintained. Date of Compliance: February 29, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. BUILDING _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 35	F 812		

daily. The Dietary Manager stated a dietary aide and a member of the nursing staff checked the nourishment rooms daily for unlabeled and undated food items. She stated the dietary department was responsible for cleaning the nourishment room refrigerators and freezers when needed. The Dietary Manager stated the dietary department did not place thawed milkshakes in the nourishment room refrigerators and a nursing staff member probably removed them from a resident's tray and placed them in the refrigerator. She stated the thawed milkshakes should not be in the refrigerator since they did not have an expiration date.

An interview with the Administrator on 02/01/24 at 12:42 PM revealed he expected all food and beverage items to be labeled and dated or used or discarded by the use-by date. He stated he expected nourishment room refrigerators and freezers to be clean and it was the dietary department's responsibility to make sure they were clean. The Administrator stated milkshakes should be dated by the dietary department when they were removed from the freezer and used or discarded within 14 days of thawing.