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{F 000}	INITIAL COMMENTS A revisit was conducted onsite from 3/27/2024 to 3/28/2024 with additional information obtained remotely through 4/5/2024. Therefore, the exit date was 4/5/2024. Tags F600, F610, F690, F759, and F880 were corrected as of 4/5/2024. Repeat tags were cited. New tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID # U6G612.	{F 000}		
{F 755} SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	{F 755}		

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

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receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, Medical Director/Physician interview, and Pharmacist interview the facility failed to remove narcotic pain medications from the medication cart within the parameters set by the physician's orders for narcotic medication; failed to follow procedures for disposal of wasted narcotic medication; and failed obtain an order for narcotic pain medication prior to removing narcotic pain medication from the medication cart. Additionally, the facility failed to have effective safeguards and systems in place to control for, account for, and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This was for three residents, (Resident #6, Resident #7, Resident #8) of three residents reviewed for pharmacy services for narcotic medication. Findings included:

1. Resident #6 was admitted to the facility on 9/13/2023 with multiple diagnoses some of which included benign neoplasm of the pituitary gland, history of cerebral infraction, and anxiety disorder.

Documentation on the current March 2024 orders revealed Resident #6 had a physician's order initiated on 10/27/2023 for Oxycodone with Acetaminophen 5-325 milligrams (mg) tablets to be administered as 1 tablet by mouth every 4 hours as needed for severe pain at the 8 to 10

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level not to exceed 3250 milligrams per day. Additional documentation on the current March 2024 orders revealed Resident # 6 had a physician's order initiated on 9/13/2023 for observation of signs and symptoms of pain to be documented using chart codes.

Documentation of the pain level of Resident #6 on the Medication Administration Record (MAR) revealed a level of 0 on 3/21/2024 written at 10:57 PM by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 4:00 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 6:00 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 8:00 PM by Nurse #5.

There was no documentation on the MAR on 3/21/2024 for the administration of Oxycodone with Acetaminophen 5-325 mg tablets for the 3:00 PM to 11:00 PM shift.

Documentation of the pain level of Resident #6 in the MAR revealed a level of 5 on 3/26/2024 at 6:54 PM written by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 3:30

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PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 5:20 PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 7:10 PM by Nurse #5. Fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 8:00 PM by Nurse #5. One hour and ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 9:10 PM by Nurse #5. Fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 10:00 PM by Nurse #5. One hour later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 11:00 PM by Nurse #5.

There was no documentation on the MAR for the administration of Oxycodone with Acetaminophen 5-325 mg on 3/26/2024 from 3:00 PM to 11:00 PM.

Documentation of the pain level of Resident #6 in the MAR revealed a level of 6 on 3/27/2024 at 6:54 PM written by Nurse #5 for the evening shift.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 3:15 PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 5:10 PM by Nurse #5. One hour and

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ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 6:20 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 8:20 PM by Nurse #5. Two hours and ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 10:30 PM by Nurse #5.

There was no documentation on the MAR for the administration of Oxycodone with Acetaminophen 5-325 mg on 3/27/2024 from 3:00 PM to 11:00 PM.

The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON revealed Nurse #5 had been working at the facility for 2 years. The DON stated that despite being severely cognitively impaired, Resident #6 was very capable and knowledgeable of when his pain medication had been given to him. The DON stated Resident #6 had been administered all the doses of Oxycodone removed from the medication cart by Nurse #5 on 3/21/2024, 3/26/2024 and 3/27/2024. The DON did not think Resident #6 would suffer any ill effects of receiving Oxycodone with Acetaminophen outside the parameters stipulated by the physician. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic

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medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #6. Nurse #5 revealed Resident #6 was complaining on the 3:00 PM to 11:00 PM shift of terrible neck pain on 3/21/2024, 3/26/2024, and on 3/27/2024 so Nurse #5 gave him Oxycodone. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Oxycodone for Resident #6, Nurse #5 stated he did not. Nurse #5 stated that if residents were in pain, he gave them pain medication.

An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide education for Nurse #5. The Pharmacist explained that Resident #6 needs to be asked what his pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist stated it had not been brought to her attention that there was any

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concern with the narcotic medications being administered outside of the orders. The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention.

The Medical Director, who was also the physician for Resident #6, was interviewed on 4/4/2024 at 2:30 PM. The Medical Director stated that Resident #6 was on a very high dose of Oxycodone and nurses should be following the parameters of the physician's order for the Oxycodone unless there was authorization to do otherwise. The Medical Director stated narcotic pain medication cannot be arbitrarily given to the residents.

2. Resident #7 was admitted to the facility on 3/22/2024 with multiple diagnoses some of which included an ankle fracture, osteoarthritis, polyneuropathy, and fibromyalgia.

Documentation on admission physician orders revealed an order for Hydromorphone (Dilaudid) 2 milligram (mg) tablets to be administered as one tablet by mouth every 6 hours as needed for pain.

Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #7 had the following information: Twenty pills of Hydromorphone (Dilaudid) 2 mg tablets were received by the facility on 3/22/2024. One tablet

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of Dilaudid 2 mg was signed out by Nurse #5 and "lost on the floor" on 3/22/2024 at 3:30 PM leaving 19 tablets remaining. The Diludid tablet that was "lost on the floor" did not have any corresponding nursing signature or initials from another nurse confirming the pill was "lost on the floor." One tablet of Dilaudid 2mg was signed out by Nurse #5 on 3/22/2024 at 3:30 PM leaving 18 tablets remaining. Four hours and thirty minutes later, one tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 8:00 PM leaving 17 tablets remaining. Two hours and forty minutes later, one tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 10:40 PM leaving 16 tablets remaining.

There was no documentation on the Medication Administration Record for the administration of the medication Dilaudid to Resident #7 on 3/22/2024. There was no documentation written by Nurse #5 revealing what the pain level of Resident #7 was or if Resident #7 obtained relief from the three doses of Dilaudid removed from the medication cart on 3/22/2024.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #7. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Dilaudid for Resident #7, Nurse #5 stated he did not.

Documentation on a Basic Interview for Mental Status (BIMS) assessment dated 3/25/2024 revealed Resident #7 was assessed as cognitively intact with a score of 15 out of 15.

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Resident #7 was interviewed on 4/1/2024 at 4:56 PM. Resident #7 said she did remember Nurse #5. Resident #7 acknowledged that she would not be able to specifically say on what date and time she received medications from Nurse #5. Resident #7 stated that on one previous occasion at another facility she was given a Dilaudid tablet of 3 mg, and she was so sleepy her family was concerned she would not wake up. Resident #7 stated she knew that she was not supposed to take more than 2 mg of Dilaudid every 6 hours, and she would not have taken that much Dilaudid in such a short time if it was offered to her.

The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made.

An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide

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education for Nurse #5. The Pharmacist explained that Resident #6 needs to be asked what his pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist confirmed that when a controlled medication was wasted, another signature or initial was needed by a nurse on the Controlled Drug Receipt/Record/Disposition form. The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention.

The Medical Director, who was also the Physician for Resident #7, was interviewed on 4/4/2024 at 2:30 PM. The Medical Director stated nurses should be following the parameters of the physician's order for the Dilaudid unless there was authorization to do otherwise. The Medical Director stated Nurse #5 should have known better than to administer that much Dilaudid within the time frame of approximately 7 hours. The Medical Director was unsure if Resident #7 could have handled that much of the medication Dilaudid.

3. Resident #8 was admitted on 8/12/2022 and had multiple diagnoses some of which included dementia, osteoarthritis, and breast cancer.

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Documentation on the current November 2023 physician's orders revealed Resident #8 had a physician's order initiated on 4/5/2023 for Oxycodone HCL (Hydrocholoride) 5 milligrams (mg) to be administered by mouth in the form of one tablet every six hours for pain.

Documentation on a Controlled Drug Receipt/Record/Disposition form revealed 60 tablets of Oxycodone HCL 5 mg tablets were received for the use of Resident #8 on 11/10/2023.

Resident #8 was discharged to the hospital on 11/13/2023 and was readmitted to the facility on 11/17/2023.

Documentation on physician orders for Resident #8 dated 11/17/2023 revealed an order for Hydrocodone-Acetaminophen oral tablets 5-325 mg to be administered by mouth every 6 hours as needed for pain for three days only until 11/20/2023.

There were no additional orders for narcotic pain medication Hydrocodone-Acetaminophen 5-325 mg in the electronic medical record for Resident #8 in the month of November 2023 or December 2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 0 on 11/21/2023 at 6:00 PM by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/21/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by

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Nurse #5 at 8:00 PM without an order to do so.

There was no documentation on the MAR (Medication Administration Record) of the administration of oxycodone 5 mg to Resident #8 on 11/21/2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 0 on 11/22/2023 at 5:34 PM.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/22/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by Nurse #5 at 8:00 PM without an order to do so.

There was no documentation on the MAR of the administration of oxycodone 5 mg to Resident #8 on 11/22/2023.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/23/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by Nurse #5 at 7:30 PM without an order to do so.

There was no documentation on the MAR of the administration of Oxycodone HCL 5 mg to Resident #8 on 11/23/2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 11/23/2023 at 9:59 PM.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record

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revealed a pain level of 5 on 12/21/2023 at 4:12 PM.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 12/21/2023 one tablet of Oxycodone HCL 5 mg was removed from the medication cart by Nurse #5 at 7:50 PM with no order to do so.

There was no documentation on the MAR of the administration of Oxycodone HCL 5 mg to Resident #8 on 12/21/2023.

Documentation on the current March 2024 Physician orders revealed an order for Resident #8 dated as initiated on 1/8/2024 for Oxycodone HCL 5 mg tablets to be administered as one tablet by mouth every 6 hours as needed for moderate to severe pain.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart by Nurse #5 on 3/22/2024 at 4:40 PM.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 3/22/2024 at 5:39 PM by Nurse #5.

Two hours and 30 minutes later, documentation on the Controlled Drug Receipt/Record/Disposition form revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart on 3/22/2024 at 7:10 PM.

Two hours and 40 minutes later, documentation

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on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart by Nurse #5 on 3/22/2024 at 10:50 PM.

There was no documentation on the MAR of the administration of Oxycodone 5 mg tablets to Resident #8 by Nurse #5 on 3/22/2024.

Documentation on the nursing staffing schedule revealed Nurse #5 worked on the hallway Resident #8 resided on 3/23/2024 for the 3:00 PM to 11:00 PM shift.

Documentation on Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5mg was removed from the medication cart on 3/23/2024 at an undiscernible time by Nurse #5 leaving 6 doses remaining.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 3/23/2024 at 5:51 PM by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5mg was removed from the medication cart by Nurse #5 on 3/23/2024 at 8:10 PM leaving 5 doses remaining.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg was removed from the medication cart by Nurse #5 on 3/23/24 at 3:00 PM leaving 4 doses remaining.

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There was no documentation on the MAR of the administration of Oxycodone 5 mg tablets to Resident #8 by Nurse #5 on 3/23/2024.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #8. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Oxycodone 5 mg for Resident #7, Nurse #5 stated he did not. Nurse #5 stated that if residents were in pain, he gave them pain medication.

The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made.

An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide

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{F 755}	Continued From page 15 education for Nurse #5. The Pharmacist explained that Resident #8 needs to be asked what her pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist confirmed that when a controlled medication was wasted, another signature or initial was needed by a nurse on the Controlled Drug Receipt/Record/Disposition form. The Pharmacist confirmed medication should only be given if there was a physician's order to do so. The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention. An interview was conducted with the Medical Director, who was also the Physician for Resident #8, on 4/4/2024 at 2:30 PM. The Medical Director confirmed nurses should be following the parameters of the physician's order narcotic pain medication unless there was authorization to do otherwise. The Medical Director stated the facility needed to monitor the Controlled Drug Receipt/Record/Disposition form versus the MAR so that the pain medication orders were followed for Resident #8, because she really needed her pain medication.	{F 755}		
{F 867} SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	{F 867}		

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§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 prevent adverse events.

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{F 867}	Continued From page 17 §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 that include feedback and learning throughout the	{F 867}		

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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 observation, record review, staff interviews, hospice staff interview, physician interview, pharmacy consultant interview, and psychiatric nurse practitioner interview the facility's Quality Assessment and Assurance

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Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation of 4/13/2021, the recertification and complaint survey of 6/30/2022, the recertification and complaint investigation of 11/2/2023, and the complaint investigation of 2/27/2024. This was for 3 repeat deficiencies in the areas of supervision to prevent accidents, hospice services, and pharmacy services. The continued failure of the facility during four federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included:

This citation is cross referenced to:

F689: Based on observation, record review, and interviews with staff, Physician, Psychiatric Nurse Practitioner, and the facility's Pharmacy Consultant the facility failed to 1) analyze Resident #2's falls to determine causative factors and implement interventions to reduce the risk for further falls and 2) ensure a paraplegic resident (Resident # 1) did not roll out of bed during care. Resident # 2 was identified to have an impacted arm fracture (a fracture that generally occurs following a fall). This was for two of three sampled residents reviewed for accidents.

During a recertification and complaint investigation survey of 4/13/2021 the facility failed to repair a loose siderail which resulted in a fall with injuries for 1 of 4 residents reviewed for accidents.

During a recertification and complaint investigation survey of 6/30/2022 the facility failed

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{F 867}	Continued From page 20 to ensure a fall mat was in place according to the care planned fall safety interventions for 1 of 3 residents reviewed for supervision to prevent accidents. During a recertification and complaint investigation survey of 11/2/2023 the facility failed to provide supervision to a resident who was assessed as a supervised smoker, while a resident was smoking in a designated smoking area, secure a resident's smoking materials and complete quarterly smoking assessments for a resident, who was assessed as no requiring supervision when smoking for 2 of 2 reviewed for accidents. F755: Based on record review, staff interview, Medical Director/Physician interview, and Pharmacist interview the facility failed to remove narcotic pain medications from the medication cart within the parameters set by the physician's orders for narcotic medication; failed to follow procedures for disposal of wasted narcotic medication; and failed obtain an order for narcotic pain medication prior to removing narcotic pain medication from the medication cart. Additionally, the facility failed to have effective safeguards and systems in place to control for, account for, and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This was for three residents, (Resident #6, Resident #7, Resident #8) of three residents reviewed for pharmacy services for narcotic medication. During a complaint investigation of 2/27/2024 the facility failed to provide pharmacy services within the time frame for a scheduled dose of medication for one of four residents observed	{F 867}		

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{F 867}	Continued From page 21 during a medication pass observation. F849: Based on observation, record review, staff interview, hospice staff interview, and physician interview the facility failed to communicate and coordinate with hospice to identify a resident had sustained a dislocated finger. This was for one (Resident # 3) of two sampled hospice residents. During a recertification and complaint investigation of 6/30/2022 the facility failed to obtain a Physician's order for hospice services for 2 of 4 residents reviewed for hospice. The facility Administrator was interviewed on 4/3/2024 at 12:55 PM. The Administrator explained that the facility interdisciplinary team met every Friday to discuss falls and accidents so that interventions could be put in place to prevent reoccurrence. The Administrator indicated he did not feel further monitoring was warranted. The Administrator stated that the facility was monitoring the issue the facility was previously cited regarding having enough of liquid medication available for the residents and monitoring the medication pass. The Administrator further explained that the facility interdisciplinary team also discussed every Friday the results of the medication pass monitoring they had just started and had not identified any other issues with pharmacy services. The Administrator was interviewed again on 4/5/24 at 8:53 AM. The Administrator indicated the facility was monitoring hospice services but the hospice nursing staff needed to communicate with the facility if there was an issue going on so it could be addressed.	{F 867}		