STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted on 8/11/24 through 8/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# NE0L11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 8/11/24 through 8/15/24. Event ID# NU30211. The following intakes were investigated: NC00211523, NC00217724, and NC00213026. 2 of 14 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident (Resident #82) who was observed to have a medication at bedside. The findings included: Resident #82 was admitted to the facility on 1/30/24. His cumulative diagnoses included diabetes and exocrine pancreatic insufficiency (a condition in which the small intestine cannot	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F554	9/4/24

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

Electronically Signed | 09/06/2024

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F 554	Continued From page 1 digest food completely because of a lack of digestive enzymes produced by the pancreas). Resident #82 re-entered the facility on 7/9/24 after a hospital stay. His physician's orders upon readmission included the following, in part: --12,000 - 38,000 units Creon to be given as 4 capsules by mouth three times a day for supplement. Take with meals. Do not crush or chew Creon capsules or its contents, and do not hold the capsule or capsule contents in your mouth. --12,000 - 38,000 units Creon to be given as 2 capsules by mouth every 12 hours as needed for supplement. May take two tablets with snacks. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 7/12/24. The MDS assessment revealed Resident #82 had intact cognition. An observation was conducted on 8/11/24 at 12:30 PM as Nurse #1 conducted a blood glucose (sugar) check for Resident #82. During the observation, the resident was observed to have a bubble-pack card of Creon capsules placed on his nightstand and within his reach. At that time, Nurse #1 stated the resident had a physician's order to keep the Creon capsules at bedside. A review of Resident #82's active physician's orders on the date of the review (8/11/24) and the resident's current care plan was conducted. A review of Resident #82's electronic medication record (EMR) included his August 2024 Medication Administration Record (MAR) and 8/11/24 Physician's Order Summary. These records revealed there were no active physician's	F 554	1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/13/2024, a corrective action was completed for resident #82 when the support nurse asked the resident if he wished to self-administer his medication. Resident indicated he had no desire to self-administer medications. On 08/13/2024, the support nurse removed the medication from the resident□s room. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08/13/2024 the current Director of Nursing (DON), Staff Development Coordinator (SDC), Assistant Director of Nurses (ADON), and Unit Support Nurse, completed an observation of 100% of all current resident rooms to ensure there were no unsecured medications at the bedside. This was completed on 08/13/2024. The results included: There were no medications observed at the bedside of any residents. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/2024, the DON and Support Nurses began education of all Full Time, Part Time, PRN licensed nurses (Registered Nurses and Licensed Practical Nurses) and Medication Aides including agency staff on facility policy related to self -administration of	

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F 554	Continued From page 2 orders which indicated it had been determined to be clinically appropriate for Resident #82 to self-administer the prescribed Creon capsules. Also, the review of Resident #82's current care plan (last revised 8/8/24) revealed the resident was not care-planned for the self-administration of his Creon medication. A second observation was conducted on 8/11/24 at 1:32 PM as the resident was asleep in his bed (he did not arouse with knocking on the door or when he was spoken to). The bubble-pack card of Creon capsules remained on his bedside tray table. 26 bubbles on the card were still intact with each bubble containing 2 Creon capsules (for a total of 52 capsules remaining in the card). The card was noted as dispensed by the pharmacy on 7/17/24. On 8/12/24 at 7:45 AM, Resident #82 was observed as a nursing staff member assisted him with his breakfast meal tray set-up. A short interview was conducted with the resident at that time. The resident was observed as he took the card of Creon capsules (placed on his bedside tray table), removed 4 capsules from the card, and took the medication. A follow-up interview and observation were conducted with Resident #82 on 8/12/24 at 8:30 AM During the interview, the resident acknowledged having a history of "stomach problems." When asked about the Creon, Resident #82 reported he has been taking this medication at bedside on his own "for some time," but could not specify how long. Upon further inquiry, he stated the nursing staff never asked him if (or when) he took this medication. He simply stated, "They don't ask."	F 554	medication process. Education will be completed by 09/04/2024. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/04/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Monitoring will be completed using the F554 Quality assurance tool. The Director of Nurses or designee will monitor compliance of the medication self-administration process and that no other meds are at bedside if the resident has not been assessed for self-administration. Monitoring of 6 resident rooms will be completed on various days of the week and shifts to assure compliance with the self-administration of medication policy. Monitoring will be completed weekly x 3 weeks then monthly x 2 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the monthly QA committee by the Director of	

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F 554	Continued From page 3 An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the facility's 100/200 Hall Unit Manager. During this interview, Resident #82's self-administration of his Creon medication was discussed. The DON indicated a resident needed to be assessed and care-planned for the self-administration of a medication. She also confirmed there should be an active physician's order for the resident to self-administer his medication.	F 554	Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/04/2024	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		9/4/24

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F 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff and Rehabilitation Director interviews, and record reviews, the facility failed to develop a comprehensive care plan which addressed a resident's contractures and the application / removal of two splints for 1 of 1 resident reviewed for limited range of motion (Resident #80). The findings included: Resident #80 was admitted to the facility on 2/26/24 with cumulative diagnoses which included hemiplegia (paralysis that affects only one side of the body) following cerebral infarction (a type of	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 1. Corrective action for resident(s)	

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F 656	Continued From page 5 stroke which occurs when blood flow to the brain is disrupted) affecting his right dominant side. An Admission Occupational Therapy (OT) Screen was completed on 2/27/24 by the facility's Occupational Therapist. This screen reported Resident #80 had contractures of his right elbow, wrist, hand, and fingers. Occupational therapy was determined to be indicated at that time. An additional notation was made which read, in part: "Patient will benefit from skilled OT services addressing all functional deficits to maximize patient's independence and safety with self-care. Patient will also benefit from addressing RUE [right upper extremity] contracture management/splinting needs." A review of Resident #80's Occupational Therapy (OT) Discharge Summary (dated 4/26/24) revealed the resident received OT services from 2/27/24 - 4/26/24. The Assessment and Summary of Skilled Services included notations on Patient Progress which read, in part: "...Patient reaching plateau/max potential at this time. Patient discharging to this facility for long-term care..." The Discharge Recommendations noted: "Discharge recommendations including nursing staff to provide assist with all self-care needs...Nursing staff to perform functional maintenance program for R [right] hand splint and R elbow splint daily. Functional maintenance program completed and training performed to nursing staff demonstrating 100% understanding." A review of Resident #80's electronic medical record (EMR) revealed a physician's order based on the OT recommendations was received on 4/26/24. The order instructed nursing staff to don	F 656	affected by the alleged deficient practice: On 8/14/2024, A corrective action was completed for resident #80 when his Care plan was reviewed and developed to include a comprehensive care plan to include the splint on by the Minimum Data Set (MDS) Nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08/14/2024 an audit which included review of the care plans for all current residents known to have a splint was completed by the MDS Nurse. This audit consisted of review to ensure there was a comprehensive care plan developed and implemented for all current residents known to have a splint that require application, monitoring, and removal of splints. This audit was completed on 08/14/2024. The results included: 5 out of 12 comprehensive care plans of residents with splints were updated. On 08/14/2024, the MDS Nurse implemented a corrective action for any residents known to have a splint who didn□t have a current comprehensive care plan. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/2024, the Director of Nurses (DON) began education of all Full Time, Part Time, PRN MDS Nurses, Registered Nurses (RN□s) Supervisors, and	

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F 656	Continued From page 6 / doff (apply and remove) Resident #80's right hand splint and right elbow splint every day shift with intermittent checks for skin redness/irritation and pain to decrease risk of further stiffness/deformity. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/24/24. The MDS section related to Cognitive Patterns indicated the resident was determined to have moderately impaired cognition. He was reported to have no refusals or rejection of care. Resident #80 required substantial/maximum assistance for all his Activities of Daily Living (ADL) except for being totally dependent on staff for chair to bed (and bed to chair) transfers. Resident #80's current care plan (last revised on 7/19/24) included an area of focus which indicated he had an ADL self-care performance deficit related to limited mobility (Date Initiated 2/28/24). The goal for this area of focus read: "I will receive staff assistance with all aspects of my daily care to ensure that all of my needs are met over the next 90 days" (Date Initiated 2/28/24; Revision on 3/15/24). The resident's current care plan did not include any information or interventions related to his contractures or application / removal of splints to his right hand and elbow as of the date of the review (8/12/24). An interview was conducted on 8/15/24 at 9:28 AM with the facility's MDS Nurse. Upon inquiry, the MDS Nurse reported the residents' care plans were developed and revised by the Interdisciplinary Team. She stated the residents' (including Resident #80's) care plans were revised quarterly.	F 656	Licensed Practical Support Nurses including agency staff on facility policy related to developing comprehensive care plans including splint application. Education will be completed by 09/03/2024. Education included: " Developing and Implementing comprehensive person-centered care plans The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. To ensure compliance, the Director of Nursing or designee will monitor for compliance using F656 QA Tool to review comprehensive care plans of residents with splints. This monitoring will consist of review of 3 residents known to have splints to ensure the resident has a comprehensive person-centered plan of care to include splints. This monitor will be completed weekly x 3 weeks and then monthly x 2 months or until resolved for	

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F 656	Continued From page 7 On 8/15/24 at 9:42 AM, the facility's Rehabilitation Director joined the discussion with the MDS Nurse related to Resident #80's care plan. At that time, the Director reported nursing staff was responsible for including information regarding the resident's splints on his care plan. Upon further inquiry, the Rehabilitation Director confirmed the use of splints should have been care planned. She added that this intervention may have been missed.	F 656	compliance with facility policy on comprehensive person-centered plan of care. Reports will be presented to the monthly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/04/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and record review, the facility failed to ensure a resident's nails were clean for 1 of 4 residents (Resident #89) who were reviewed for Activities of Daily Living (ADLs). The findings included: Resident #89 was admitted to the facility on 8/1/24 from a hospital. Her cumulative diagnoses included a history of cerebral infarction (a type of	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have	9/4/24

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F 677	Continued From page 8 stroke which occurs when blood flow to the brain is disrupted) and recurrent urinary tract infarctions (UTIs). An admission Minimum Data Set (MDS) assessment dated 8/7/24 revealed Resident #89 had severely impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #89 required partial to moderate assistance for eating with substantial/maximal assistance from staff for toileting, bathing, dressing, and personal hygiene. The resident's care plan included the following area of focus, in part: I have an ADL self-care performance deficit related to limited mobility (Initiated on 8/5/24). An observation was conducted on 8/11/24 at 9:54 AM of Resident #89 as she was lying in her bed with her left arm bent at the elbow and her left hand holding the call light button up in the air. The call light outside her doorway was lit at the time of the observation. The resident's nails on her left hand were observed to be 1/8 inch (") to 1/4" long with a dark brown/black substance present underneath each of the 5 fingernails on that hand. At the time of this observation, Resident #89's Nurse Aide (NA) entered the room, asked the resident what was needed, and closed the door to provide care. Another observation was conducted on 8/12/24 at 11:48 AM of Resident #89. The resident was observed sitting in a wheelchair in her room with a family member sitting next to her while attempting to feed Resident #89 her noon meal. Only three (3) fingers of the resident's right hand were visible at the time of this observation. A	F 677	been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/13/2024, resident #89 received nail care from her family. According to the 2567, the family member reiterated that she herself had just cleaned the resident's fingernails on both hands. The observation made at that time confirmed the resident's fingernails were clean. No further corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 08/13/2024 the Director of Nurses (DON) initiated an audit to be completed on 100% of all current residents. This audit was completed by department managers to identify any residents who had dirty nails that were not trimmed to the desired length according to their preference. This audit was completed on 08/13/2024. The results included: any resident that needed nail care it was completed at that time. On 08/13/2024, a correction action was completed when any resident identified as requiring nail care received nail care. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/2024, the DON, Registered Nurse Supervisor (RN), and the Licensed	

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F 677	Continued From page 9 dark brown/black substance was observed underneath each of the three right hand fingernails observed. Resident #89's fingernails were again observed during a Medication Administration Observation conducted on 8/13/24 at 9:14 AM. All 5 fingers on each hand could be viewed at that time. The fingernails varied from 1/8" to 1/4" in length. Each of the fingernails on both hands had a dark brown/black substance under the nail which was noted during the initial observations made on 8/11/24 and 8/12/24. An interview and observation was conducted on 8/13/24 at 11:34 as the resident's family member was visiting Resident #89 in her room. The resident was lying in bed with her right hand placed on top of her bed covers. Her fingernails were clean at that time. When the resident's family member was asked if someone had been in to clean Resident #89's fingernails, the family member stated, "I did it. I can't stand to see them so dirty." The family member reiterated that she herself had just cleaned the resident's fingernails on both hands. The observation made at that time confirmed the resident's fingernails were clean and the dark brown/black substance previously observed under her nails was gone. On 8/13/24 at 2:47 PM, Nurse Aide (NA) #1 was interviewed. NA #1 was identified as the first shift nurse aide who was assigned to care for Resident #89 on 8/13/24. During the interview, the NA was asked when a resident's fingernails were cleaned. NA #1 stated she would clean the resident's nails whenever she noticed they needed it. Upon further inquiry, she reported the nails would also be cleaned on bath/shower days	F 677	Practical Support Nurse (LPN) began reeducation of all full time, part time, as needed (PRN) licensed nurses, RN□s and LPN□s and Certified Nursing Assistants (CNA□s), including agency staff on the right to receive nail care in a manner that is requested, and necessary to maintain grooming. This education included: " A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F677 ADL Quality Assurance Tool weekly x 3 weeks then monthly x 2 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to	

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	345311	A. BUILDING _____ B. WING _____	C 08/15/2024

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F 677	Continued From page 10 (twice weekly). When the NA was informed of the family member cleaning her nails earlier that morning because she didn't like seeing them so dirty, the NA reported she had not noticed the resident needed to have her nails cleaned. NA #1 stated that if she had noticed the fingernails were dirty, she would have cleaned them. An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the 100/200 Hall Unit Manager. During the interview, the concern regarding the multiple observations of Resident #89's dirty fingernails was discussed. The DON was also informed of Resident #89's family member's interview and involvement in cleaning the resident's fingernails because they were dirty. In response, the DON reported her expectation was for nail care to be done on each resident's shower days and as needed.	F 677	assure that dependent residents are receiving nail care as a part of their ADL care. This will include auditing 6 residents on various halls to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/04/2024	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		9/4/24

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F 688	Continued From page 11 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the resident, staff, and Occupational Therapist, and record reviews, the facility failed to follow a physician's order to apply two splints (one to the resident's right hand and one to his right elbow) to prevent further contracture for 1 of 1 resident reviewed for limited range of motion (Resident #80). The findings included: Resident #80 was admitted to the facility on 2/26/24 with cumulative diagnoses which included hemiplegia (paralysis that affects only one side of the body) following cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted) affecting his right dominant side and aphasia. An Admission Occupational Therapy (OT) Screen was completed on 2/27/24 by the facility's Occupational Therapist. This screen reported Resident #80 had contractures of his right elbow, wrist, hand, and fingers. Occupational therapy was determined to be indicated at that time. An additional notation was made which read, in part: "Patient will benefit from skilled OT services addressing all functional deficits to maximize patient's independence and safety with self-care. Patient will also benefit from addressing RUE [right upper extremity] contracture management/splinting needs." The resident's admission Minimum Data Set	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/14/2024, a corrective action was obtained for resident # 80 when the therapist assisted nursing staff with the application of the right hand and right elbow splint and ensured that the splint had been applied as ordered. The Minimum Data Set (MDS) Coordinator reviewed the resident□s task to assure there was a task for splint application. On 08/14/2024, the therapist completed an assessment to ensure there was no increase in resident # 80□s contracture. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 08/14/2024, the Director of Nurses	

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F 688	Continued From page 12 (MDS) dated 3/1/24 revealed the resident was assessed to have moderately impaired cognition with no refusals or rejection of care. Resident #80's Care Area Assessment (CAA) worksheet (dated 3/3/24) related to his functional abilities read, in part: " ...English is his primary language however resident has aphasia; he is able to nod appropriately when asked yes or no questions ..." A review of Resident #80's Occupational Therapy Discharge Summary dated 4/26/24 reported the resident's dates of OT service were 2/27/24 - 4/26/24. The Assessment and Summary of Skilled Services included notations on Patient Progress which read, in part: "...Patient reaching plateau/max potential at this time. Patient discharging to this facility for long-term care..." The Discharge Recommendations noted: "Discharge recommendations including nursing staff to provide assist with all self-care needs. Encourage OOB [out of bed] activity daily seated in standard w/c [wheelchair] to continue to maintain strength/activity tolerance....Nursing staff to perform functional maintenance program for R [right] hand splint and R elbow splint daily. Functional maintenance program completed and training performed to nursing staff demonstrating 100% understanding." A review of Resident #80's electronic medical record (EMR) revealed a physician's order was received on 4/26/24 for nursing staff to donn/doff (apply and remove) Resident #80's right hand splint and right elbow splint every day shift with intermittent checks for skin redness/irritation and pain to decrease risk of further stiffness/deformity.	F 688	(DON) initiated an audit of all current residents with orders for splints. This audit consisted of review the medical record for any residents with orders for splints to ensure that all ordered splints were being applied as ordered. This audit was completed on 08/14/2024. The results included: 12 out of 12 residents had current splint orders. On 08/14/2024, the MDS Coordinator audited all current residents with orders for splints to ensure that all splints had a care plan and task in the medical record. This audit was completed on 08/14/2024. The results included: 5 out of 12 comprehensive care plans of residents with splints were updated. On 08/14/2024, a corrective action was completed when the MDS Coordinator updated the task to reflect splint application. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/2024, the DON, Registered Nurse Supervisor (RN), and the Licensed Practical Support Nurse (LPN) began reeducation of all full time, part time, as needed (PRN) licensed nurses, RN□s and LPN□s and Certified Nursing Assistants (CNA□s), including agency staff on splint application. This education included: " Reasons for Splints " The CNA and Nurse role with splint application The DON or designee will be responsible	

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F 688	Continued From page 13 The resident's most recent MDS was a quarterly assessment dated 5/24/24. The resident was reported to have unclear speech but was assessed to usually understand and usually be understood. The MDS section related to Cognitive Patterns indicated the resident was able to complete the Brief Interview for Mental Status (BIMS) and was determined to have moderately impaired cognition. He was reported to have no refusals or rejection of care. Resident #80 required substantial/maximum assistance for all his Activities of Daily Living (ADLs) except for being totally dependent on staff for chair to bed (and bed to chair) transfers. Resident #80's current care plan (last revised on 7/19/24) included the following area of focus, in part: --I have an ADL self-care performance deficit related to limited mobility (Date Initiated 2/28/24). The goal for this area of focus read: "I will receive staff assistance with all aspects of my daily care to ensure that all of my needs are met over the next 90 days (Date Initiated 2/28/24; Revision on 3/15/24). An initial observation was conducted on 8/11/24 at 10:05 AM of Resident #80 as he was lying in bed. The resident was not verbal at that time. No splints were observed on the resident's arm during this observation. Additional observations were made of Resident #80 on each of the following dates/times: --On 8/12/24 at 8:45 AM, Resident #80 was observed to be dressed in street clothes and with shoes on his feet as the Nurse Aide (NA) was preparing to get him out of bed for the day. Both	F 688	for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirement. The DON or designee will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The Director of Nursing will monitor all residents with splint orders to ensure compliance with splint application and documentation of the task. This monitor will be completed by observing 5 residents weekly on random shifts and random days of the week (to include weekends) to ensure compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information	

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F 688	Continued From page 14 of the resident's hands and wrists appeared to be contracted at the time of the observation. No splints were applied to his right arm. --On 8/12/24 at 3:35 PM, an observation was made of the resident while he was lying in bed with his head of bed raised. No splints were observed to be applied to his right arm. On 8/14/24 at 1:10 PM, an observation of Resident #80 revealed he was dressed in street clothes and sitting in a wheelchair in his room. He did not have splints applied to his right arm. The resident was not verbal but could nod or shake his head to answer the questions asked. When asked if he had a splint for his right arm, the resident nodded his head "yes." When asked if the splint was put on him every day, he shook his head "no." When asked, Resident #80 could not communicate as to where the splints were kept. An interview was conducted on 8/14/24 at 1:15 PM with a Nurse Aide (NA) #3 who was observed to be working on Resident #80's hall. When asked, the NA reported she was not certain if Resident #80 had a splint for his contracture but added that she had not been assigned to care for him very often. NA #3 identified NA #1 as the nurse aide who was assigned to care for Resident #80. An interview was conducted on 8/14/24 at 1:18 PM with Nurse #3. Nurse #3 identified herself as the hall nurse assigned to care for Resident #80. At that time, the nurse stated she was not sure who was responsible to apply splints for this resident. After consulting with the 100/200 Hall Unit Manager, Nurse #3 returned and reported she was told it was the rehab's (Rehabilitation Department's) responsibility to donn and doff the	F 688	Manager, and the Dietary Manager. Date of Compliance: 09/04/2024	

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splints for Resident #80.

On 8/14/24 at 1:22 PM, an interview with the facility's Occupational Therapist. During the interview, the therapist reported when the resident was discharged from therapy services, rehab provided education to the nursing staff with instructions (orders) in the resident's EMR on how and when to don/doff the splints. She reported the splints should be kept in the resident's room. The therapist stated the splints were intended to be put on in the AM (morning) after morning care and taken off around 3:00 PM before the shift change.

An interview was conducted on 8/14/24 at 1:28 PM with NA #1. NA #1 confirmed she was currently assigned to care for Resident #80 on the first shift. During the interview, the NA was asked where the resident's splints were stored. The NA stated she did not know, and reported she did not even know the resident had a splint(s). NA #1 stated she was new to the facility, but added this was the 3rd consecutive week she had been scheduled/assigned to work with Resident #80 on first shift (7:00 AM - 3:00 PM). The NA stated, "I have worked with him, but nobody told me he has one [a splint]." NA #1 was then observed to be joined by NA #3 as they entered Resident #80's room and asked the resident if he knew where his splint was. Resident #80 could not tell them but consented for the NAs to look for the splint(s). The NAs found two splints lying on the bottom of his hanging clothes closet. At that time, NA #1 stated she did not know how to apply the splints. NA #3 responded by telling her to check the Resident #80's Kardex (an electronic record generated to provide details on the type of care a resident

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F 688	Continued From page 16	F 688		

required) for guidance. The two NAs were observed as they began to apply the splints for Resident #80.

An interview was conducted on 8/14/24 at 1:57 PM with the facility's interim Director of Nursing (DON) as she provided a copy of Resident #80's Kardex for review. The Kardex did not include information related to the resident's contracture(s) or donning/doffing his splint(s). When asked if she knew about the concern related to failure of the facility to apply the resident's splints daily as ordered, the DON stated nursing did clarify the order and it was "on nursing" to put the splint on during the day shift and to take it off on the evening shift each day.

Accompanied by the DON, an observation was conducted on 8/14/24 at 2:00 PM of Resident #80. He was observed to have one of his splints placed on his right wrist/hand and one splint placed on his left wrist/hand. Upon leaving the room, the DON was overheard telling the resident she would need to remove the splint from his left arm until nursing received clarification for that splint.

A follow-up interview was conducted on 8/14/24 at 2:05 PM with both NA #1 (coming out of an adjacent room) and the Occupational Therapist as she was passing by in the hallway. When asked, the therapist reported one splint for Resident #80 was for his right wrist/hand and the other splint was for his right elbow. During the follow-up interview with NA #1, the NA reiterated she had worked full time with Resident #80 on the first shift and she had no knowledge of him needing splints applied. When asked if another staff member may have applied splints for the

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F 688	Continued From page 17 resident on the days she was assigned to care for Resident #80, NA #1 adamantly stated that the resident did not have splints applied to him at any point when she was assigned to work with him. An interview was conducted on 8/14/24 at 4:00 PM with the facility's interim Director of Nursing (DON). During the interview, the DON reported she would have expected Resident #80's splints to be applied to his arm sometime during the nursing staff's first shift and removed on the second shift (3:00 PM - 11:00 PM). She explained that when rehab turned over the splinting to the nursing staff, the donning and doffing of the splints changed from a therapy task to a nursing task that either the NAs or nurses could complete. The DON reported at the time rehab turned over the task, they would have provided education to the nursing staff on how to complete the task of donning and doffing Resident #80's splints.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		9/4/24

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F 690	Continued From page 18 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and hospital and facility record reviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 2 residents (Resident #89) reviewed with urinary catheters. The findings included: Resident #89 was admitted to the facility on 8/1/24 from a hospital. Her cumulative diagnoses included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted) and recurrent urinary tract infections (UTIs). An admission Minimum Data Set (MDS)	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 690 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 690	Continued From page 19 assessment dated 8/7/24 revealed Resident #89 had severely impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #89 required partial to moderate assistance for eating with substantial/maximal assistance from staff for toileting, bathing, dressing, and personal hygiene. Resident #89 was assessed as always incontinent of bladder and bowel. A review of Resident #89's hospital Emergency Department (ED) records included the ED Physician Report dated 8/10/24 at 9:40 AM which reported the resident was sent out to the hospital on 8/10/24 for further evaluation of a low sodium level. The ED Physician Report dated 8/10/24 at 9:40 AM indicated Resident #89 reported abdominal pain while in the ED and noted she had been treated for a UTI at the end of July 2024. The resident was found to have a UTI and an external vaginal yeast infection. An oral antibiotic and topical treatment for the yeast infection were prescribed and an indwelling urinary catheter was placed due to urinary retention. Resident #89's discharge medications included a continuation of cefpodoxime (an oral antibiotic) and nystatin powder (a topical treatment for the yeast infection) for 7 days. The resident was discharged back to the facility on 8/10/24. The resident's care plan included the following area of focus, in part: I have an indwelling (urinary) catheter (Initiated on 8/11/24). An initial observation was conducted on 8/11/24 at 9:54 AM of Resident #89 as she was lying in her bed with her left arm bent at the elbow and her left hand holding the call light button up in the	F 690	On 8/13/2024, the staff nurse completed a corrective action when the for resident #89 when the indwelling catheter was discontinued. No further correction action was required. The physician was notified of the above information. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/13/2024, the Director of Nurses (DON) and Licensed Practical Support Nurse (LPN) completed a 100% audit of current residents with orders for indwelling catheters to ensure the catheter bags were secured to the bed frame and not touching the floor. Results of the audit indicated that none of the indwelling catheter bags were touching the floor and they were all secured properly to the bed frame. From 8/14/2024 -9/3/2024 department managers and clinical leadership completed random audits of current residents with orders for indwelling catheters to ensure the catheter bags were secured to the bed frame and not touching the floor. Results of the audit indicated that none of the indwelling catheter bags were touching the floor and they were all secured properly to the bed frame. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur:	

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	345311	A. BUILDING _____ B. WING _____	C 08/15/2024

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F 690	Continued From page 20 air. The call light outside her doorway was lit at the time of the observation. A urinary catheter bag was observed to be hanging off the bedframe on the resident's right side of the bed (with a solid, white-colored side of the bag facing the doorway). The entire bottom of the urinary catheter bag was resting on the floor. The bag did not have a detachable cover. At the time of this observation, Resident #89's Nurse Aide (NA) entered the room, asked the resident what was needed, and closed the door to provide care. When the NA exited the room, the urinary catheter bag was observed as the bag's bottom remained on the floor. An additional observation was conducted on 8/11/24 at 11:20 AM as the bottom of Resident #89's urinary catheter bag was lying on the floor of the resident's room. The urinary catheter bag did not have a detachable cover. On 8/11/24 at 1:33 PM, the resident's urinary catheter bag was observed to be positioned approximately 1" above the floor. On 8/13/24 at 2:40 PM, Resident #89 was observed to be asleep in her bed with her urinary catheter bag hanging from the right side of the bed and again touching the floor. Nurse #2 was approached while she was working at the Nurse's Station. Nurse #2 was identified as the hall nurse assigned to care for Resident #89. Upon request, the nurse was accompanied to the resident's room. As the nurse entered Resident #89's room, she was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, "It shouldn't touch the floor." The nurse stated she thought the urinary catheter bag ended up touching the floor due to	F 690	Education: On 8/28/2024, the DON and Registered Nurse Supervisor (RN), began education to all RN□s and Licensed Practical Nurses (LPNs); full time, part time, PRN staff, and agency staff on catheter education how to secure catheter bag off the floor. This education includes: " Securement device is in place " Infection control is maintained " Catheter bags should never touch the floor The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. This audit will include 4 random observations on different days/shifts for current residents to ensure the catheter bags were secured	

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F 690	Continued From page 21 the low position of her bed. Nurse #2 was observed as she repositioned the urinary catheter bag and raised the bed slightly, so the bag was off the floor. An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the 100/200 Hall Unit Manager. During the interview, the DON reported she expected the nursing staff to attach a urinary catheter bag to a resident's bed frame and position the bag so it would not touch the floor.	F 690	to the bed frame and not touching the floor. The DON or designee will monitor for compliance the proper way to secure an indwelling catheter bag to ensure it is not touching the floor. Reports will be presented to the monthly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 9/04/2024	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.1% for 2 of 5 residents (Residents #15 and #69) observed during the Medication Administration Observation.	F 759	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the	9/4/24

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F 759	Continued From page 22 1. On 8/11/24 at 10:37 AM, Nurse #7 was observed as she prepared and administered 5 medications to Resident #15. The medications administered included one 81 milligram (mg) aspirin chewable tablet. A review of Resident #15's medication orders revealed the resident had a current order for an 81 mg "EC [enteric-coated] tablet delayed release" aspirin to be given as one tablet by mouth one time a day (initiated on 1/3/24). An interview was conducted on 8/11/24 at 1:02 PM with Nurse #7. During the interview, the discrepancy in the formulation of the 81 mg aspirin tablet administered to Resident #15 was discussed. The nurse pulled the two different formulations of the 81 mg aspirin stock medications (chewable tablets and enteric coated/delayed release tablets) from the medication cart drawer. Nurse #7 confirmed she gave the 81 mg chewable tablet to Resident #15 instead of the enteric coated/delayed release formulation ordered for Resident #15. 2. On 8/13/24 at 9:22 AM, Medication (Med) Aide #1 was observed as she prepared and administered 7 medications to Resident #69. The medications administered included one tablet of 600 milligrams (mg) calcium / 400 units Vitamin D (a combination medication) taken from a stock bottle stored on the medication cart. A review of Resident #69's medication orders revealed the resident had a current order for: 600 mg calcium / 200 units Vitamin D to be given as one tablet by mouth one time a day for supplement.	F 759	facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F759 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/13/2024 the Director of Nurses assessed resident #15, there were no findings of harm to resident #15. Additionally, the MD was notified of medication errors for resident #15 on 08/13/2024 and there were no new orders. On 08/13/2024 the Director of Nurses assessed resident #69, there were no findings of harm to resident #69. Additionally, the MD was notified of medication errors for resident #69 on 08/13/2024 and there were no new orders. 2. Corrective action for residents with the potential to be affected by the deficient practice: Starting from 8/16/2024 □ 9/3/2024, the Licensed Practical Support Nurse (LPN) and Pharmacy Consultant completed random medication administration observations with licensed nurses and medication aides to validate staff were following the 6 rights of medication administration. Medication administration observations were completed on: 09/03/2024. The results included: one issue identified and corrected immediately. On 08/31/2024, the DON initiated random	

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F 759	Continued From page 23 An interview was conducted with Med Aide #1 on 8/13/24 at 10:18 AM. During the interview, the discrepancy in the dosage of the calcium / Vitamin D combination medication administered to Resident #69 was discussed. The Med Aide pulled the stock bottle of the medication given to Resident #69 from the medication cart. Upon review of the dosage of Vitamin D in the combination medication administered, she stated the resident should have received a calcium / Vitamin D dosage of 600 mg / 200 units as prescribed. Med Aide #1 reported she would inform her Unit Manager of the discrepancy between the dosage of the calcium / Vitamin D given versus the dosage ordered for Resident #69. An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the facility's 100/200 Hall Unit Manager. During this interview, the results of the Medication Administration Observation were discussed. When asked, the DON stated she would expect the nursing staff to "follow the orders" when administering medications. She added that if clarification was needed for an order, a Medication Aide would be expected to consult with her nurse and a nurse would be expected to contact the provider as needed.	F 759	medication competencies to validate staff were following the 6 rights of medication administration. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/28/2024 the DON began educating all full time, part time, and prn licensed nurses Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides including agency staff on the following topics: " Prevention of medication errors " Following Medication orders " Following the 6 rights of medication administration . The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or Designee will monitor compliance utilizing the F759 Medication	

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F 759	Continued From page 24	F 759	Observation Tool weekly and medication competencies x 3 weeks then monthly x 2 months or until resolved. Monitoring will occur on various shifts and days of the week to include weekends to assure that we are free of medication error rates less than 5 percent. This will include monitoring medication pass and completing medication competencies of 4 employees RN□s, LPN□s, or medication aides on various shifts, halls, and days to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/04/2024	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		9/4/24

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F 761	Continued From page 25 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Discard a stock medication without a legible expiration date stored on 1 of 2 medication (med) carts observed (200 Hall Med Cart); and 2) Dispose of loose, unidentified tablets observed in the drawer of 1 of 2 med carts observed (100 Hall Med Cart). The findings included: 1. On 8/12/24 at 2:45 PM, an observation of the 200 Hall Medication (Med) Cart was conducted in the presence of Medication Aide (MA) #1 and the 100/200 Hall Unit Manager. During the observation, a stock bottle of 10 milligram (mg) cetirizine (an over-the-counter antihistamine) containing approximately 20 tablets was found on the med cart. A hand-written date on the bottle indicated it was opened on 6/11/24. However, the manufacturer's expiration date on the bottle was not legible. When asked, both the MA and the Unit Manager reviewed the bottle of cetirizine and confirmed the expiration date could not be determined. A follow-up interview was conducted on 8/12/24 at 3:25 PM with the Unit Manager.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/12/2024, a corrective action was completed when the Licensed Practical Support Nurse (LPN) removed the medication where the expiration date had rubbed off and removed the loose pills in the cart. Additionally, the LPN reviewed cart 2 and cart 3 to ensure there were no medications with the expiration date rubbed off or loose pills in the cart. 2. Corrective action for residents with the	

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F 761	Continued From page 26 During this interview, the Unit Manager confirmed the bottle of cetirizine found without a legible expiration date would be discarded. 2. An observation of the 100 Hall Med Cart was conducted on 8/12/24 at 2:30 PM with Nurse #2 in the presence of the 100/200 Hall Unit Manager. The observation revealed five (5) loose, unidentified tablets of varying sizes found on the bottom of the top drawer of the medication cart. The unidentified tablets included two large, white round tablets; two small, white round tablets, and 1 medium-sized white, round tablet. Upon inquiry, neither the nurse nor the Unit Manager could identify the tablets. The Unit Manager reported the loose, unidentified tablets needed to be discarded. An interview was conducted on 8/13/24 at 3:51 PM with the facility's interim Director of Nursing (DON) in the presence of the facility's 100/200 Hall Unit Manager. During this interview, the observations made during the Medication Storage Facility Task were discussed. When asked, the DON stated the nurses were responsible for checking the expiration dates of medications stored on the med carts. In addition, she reported the nurse management staff routinely followed up on checking the medication storage on the med carts.	F 761	potential to be affected by the alleged deficient practice. Beginning on 08/13/2024, the Director of Nurses (DON) and LPN Support Nurse audited all medication carts, treatment carts, and medication rooms and removed any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. No resident was found to be affected by the deficient practice. In order to ensure that no resident was affected, a continued random audits of the facility medication carts, treatment carts, and medication room was conducted by the DON and LPN Support Nurse to ensure there were no drugs and biologicals that were not labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrections were made immediately where indicated. Random audits continued until 09/3/2024 at which time auditing was transitioned to random monitoring on various shifts, days, including weekends. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 08/28/2024, the DON began educating	

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F 761	Continued From page 27	F 761	all full time, part time, agency staff, and PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. The DON or designee will ensure this information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 09/3/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tools weekly x 3 weeks then monthly x 2 months. This monitoring will include at least 1 observation per week of each medication cart, treatment cart and medication room. The DON or designee will monitor for compliance with labeling drugs and biologicals to ensure that they are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Reports will be presented to the weekly Quality	

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F 761	Continued From page 28	F 761	Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/4/2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records,	F 842		9/4/24

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 30 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff and consultant pharmacist interviews the facility failed to: 1) Maintain documentation of the pharmacist's Monthly Medication Reviews (MMRs) within the facility and readily available for review; and 2) Retain documentation of the physician's review and response to the pharmacist's findings / recommendations in the resident's medical record. This occurred for 2 of 5 residents reviewed for Unnecessary Medications (Resident #26, and Resident #30). Findings included: 1a. A review of Resident #26's electronic medical record was conducted and included the "Pharmacy Progress Notes" with the monthly Medication Regiment Review (MRR) completed by the facility's consultant pharmacist. This review revealed MRRs were documented as completed during the past year on each of the following dates: 9/21/23, 10/23/23, 11/16/23; 12/18/23,1/22/23, 2/4/24 and 2/19/24 (upon the resident's re-admission to the facility), 3/18/24, 4/22/24, 5/24/24, 6/18/24 and 7/15/24. Resident #26's electronic medical record did not include the monthly MRRs for 1/22/24 and 5/24/24 recommendations nor the signed provider's review and response (documented on a "Note to Attending Physician/Prescriber") for any pharmacist's findings / recommendations generated on these dates. 1b. A review of Resident #30's electronic medical	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08/16/2024, the Director of Nurses (DON) completed a corrective action by ensuring all current residents□ July 2024 Monthly Medication Reviews (MMR)□s were completed and properly maintained in the resident records. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 08/16/2024, the Director of Nurses (DON) completed a corrective action by auditing all current residents□ July 2024 MMR□s. This audit consisted of review of all July 2024 MMR□s to ensure that each was reviewed and acted upon and properly maintained in the resident records. This was completed on 08/16/2024. The results included that all	

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record was conducted and included the "Pharmacy Progress Notes" with the monthly Medication Regiment Review (MRR) completed by the facility's consultant pharmacist. This review revealed MRRs were documented as completed for the following dates: 1/18/24 (initial review for admission to the facility), 1/23/24, 2/20/24, 3/19/24, 4/23/24, 5/26/24, 6/19/24, and 7/24/24. Resident #30's electronic medical record did not include the monthly MRRs for 2/20/24 and 5/26/24 recommendations nor the signed provider's review and response (documented on a "Prescriber Recommendation Form") for any pharmacist's findings / recommendations generated on these dates.

A telephone interview was conducted on 8/14/24 at 3:35 PM with the facility's consultant pharmacist. The Pharmacist stated all recommendation after their monthly MMR were sent in an email to the Director of Nursing (DON), Administrator and Pharmacy Nurse Consultant. The Pharmacist stated these recommendations were placed in the DON's office. She further stated that the previous DON was asked multiple times to place the documentations / recommendations and the signed provider's review and response (documented on a "Note to Attending Physician/Prescriber") from any pharmacist's findings / recommendations in the resident's electronic records. These have not been uploaded in the electronic records. The recommendations were sent as pending the following month due to no availability of the documentation.

During an interview on 8/15/24 at 12:11 PM, the Director of Nursing (DON) indicated she was interim and was hired 7/18/24. The DON stated

current residents July 2024 MMRs were completed.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 08/28/2024, the DON in serviced the Interdisciplinary team including the Registered Nurse (RN) Supervisor, the Licensed Practical Support Nurse (LPN), Health Information Manager (HIM), and the Central Supply Manager on their role in reviewing, completing, and maintaining the records to follow up on MRRs. This education included:
" The process to review and act upon MRR□s for licensed nurses
" Maintaining MRR in the resident records

The DON or designee will be responsible for ensuring this information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09/03/2024.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements.

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F 842	Continued From page 32 when she was hired, she was made aware by the Nurse Consultant about the concerns expressed by the Pharmacy. The Pharmacy had notified the facility that the resident's medication recommendations were not in the medical records. The DON indicated a plan of correction was put in place for the identified concern. The Pharmacy would emailed the recommendations to the DON. The nurses would go through the nursing recommendations and the DON would forward the Physician recommendations to the Physician. The Physician would reviewed the recommendations with approval or denial of the recommendations and would resend them back to the DON. The DON stated she would reviews the signed documentation and ensured that the recommendations were followed. The documentation was given to the Health Information Manager (medical record staff) and would be uploaded in the resident's electronic medical record. The DON indicated that prior to the Plan of correction these processes were not happening. The documents were kept in folders in the DON's office. These documents were not 100% reviewed by the Physician and they were inconsistent. She was unsure if the previous DON was forwarding the recommendations to the Physician. Some of the recommendations were also missing. The DON stated on 7/25/24 a root cause analysis was started, and audits and education was also in process. All Nurse supervisors, and DON were educated by the Nurse Consultant. The education was on the topic on " Pharmacy Consults - procedure regarding handling monthly pharmacy recommendations and reports". All the staff completed the education on the 7/25/24. Weekly 3 residents records were randomly selected and monitored for any pharmacy recommendations.	F 842	The Director of Nurses, or designee will monitor compliance utilizing the F842 Monitoring Tool weekly x 3 weeks then monthly x 2 months. The monitoring will review the resident record to ensure MMR□s are being maintained in the resident record. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director, Business Office Manager, and the Dietary Manager. Date of Compliance: 09/04/2024	

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The DON stated that two weeks of audits were completed and there were no issues. The DON further stated the Pharmacy start their monthly medications reviews on 20th of each month and recommendation would be sent to the DON. All the procedure would be followed to ensure compliance. Audits would be conducted weekly for 3 weeks and monthly for 2 months. All audits will be discussed in Quality Assurance. If any issues/ concerned occurred than monitoring would happen more often and would continue until there was no error. The plan of correction compliance date was 8/1/24. The DON stated she was unable to find Resident #26's 1/22/24 and 5/24/24 recommendations and Resident #30's 2/20/24 and 5/26/24 recommendations.

During an interview on 8/15/24 at 12:28 PM, Nurse Consultant indicated in July she was made aware by the Consultant Pharmacist regarding the recommendations provided by the pharmacy to the facility. The Nurse Consultant further indicated she had a discussion with the Administrator, Physician, Interim DON and Nurse Supervisor regarding the concern brought up by the pharmacy. The Nurse Consultant stated she was not aware if there were any issues with the previous DON regarding following up with the recommendations. The root cause analysis was completed, and plan of correction was put in place. All resident's records were audited to identity any missing recommendations. DON and Nurse Supervisors were educated, and audit tools were put in place. The Nurse Consultant stated the DON was conducting weekly audits to ensure there was no errors.

During an interview on 8/15/24 at 12:33 PM, the Administrator stated the Nurse Consultant had

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F 842	Continued From page 34 notified her about the pharmacy concerns. A plan of corrections was immediately started. All residents' records were audited to identify any concerns. The Physician was also made aware. Plan of corrections and audit tools were put in place. The Administrator stated the monitoring would continue until there was no error and in compliance. The audit results would be discussed in QA meeting. The Pharmacy documentations were now scanned in resident's electronic medical records. The plan of correction did not include corrective action for Resident #26 and Resident #30. During an interview on 8/15/24 at 12:11 PM, the Director of Nursing (DON) stated she was unable to find Resident #26's pharmacy recommendations for 1/22/24 and 5/24/24 and Resident #30's 2/20/24 and 5/26/24 recommendations.	F 842		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to prevent a buildup of dust on, and condensation on and around the kitchen Heating Ventilation and Air Conditioning (HVAC) vent, which resulted in moisture damage to the ceiling in the kitchen. These practices had the potential to affect food served to all residents.	F 921	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	9/4/24

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F 921	Continued From page 35 Findings included: A. An observation of the kitchen on 8/13/24 at 11:40 AM revealed a puddle of water on the floor which was approximately the size of a golf ball. The puddle was observed in the kitchen walkway in front of the table where the juice dispenser, iced tea maker, and coffee maker were placed. Observation of the ceiling above the puddle of water revealed an HVAC vent which had a buildup of condensation, and the condensation was dripping onto the floor, contributing to the puddle of water on the floor. The HVAC vent was approximately 2 feet by 2 feet and had a brownish black color around the edges with a visible buildup of dust. Further observation revealed an area extending approximately 6 inches around the perimeter of vent was discolored as if it were a water stain. During an interview on 8/13/24 at 11:44 AM, the Dietary Manager stated the water dripped from the HVAC vent when there was a lot of humidity in the air. The water would drip out of the vent some days and would not drip other days. She indicated the vent was dripping water for past few months and the facility Administrator was aware of it and she had not reported it to maintenance. The dietary Manager stated maintenance staff were responsible for cleaning the dust on the vent. B. An observation of the kitchen's ceiling on 8/13/24 at 11:40 AM revealed approximately 18 to 24 inches (L X W) area of paint, next to the vent, had come loose from the ceiling and the paint was beginning to sag down adjacent to the vent. The loose area of paint was above the table where the juice dispenser, iced tea maker, and	F 921	constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F921 1. Corrective action for resident(s) affected by the alleged deficient practice. A. On 08/13/2024, a corrective action was completed when the Maintenance Director cleaned the kitchen Heating Ventilation and Air Conditioning (HVAC) vent. On 08/13/2024, the Maintenance Director contacted HVAC vendor who was able to inspect and service thee HVAC unit on 08/13/2024. B. On 08/13/2024, a corrective action was completed when the Maintenance Director patched an area approximately 18 to 24 inches, next to the vent. Maintenance Director reached out to contractor, to obtain estimates to paint kitchen. Contactor is scheduled to begin refurbishment of kitchen starting on 09/09/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 08/13/2024, the Maintenance Director completed a corrective action by inspecting all areas in the kitchen that needed repair. This was completed on 08/29/2024. The results included three areas that needed repair. Temporary repairs have been completed. Additional repairs/refrubishment of the kitchen will began with contracted vendor starting on 09/09/2024.	

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F 921	Continued From page 36 coffee maker were placed. The observation revealed visible condensation on the ceiling and water puddle in front of the table. A brownish black color remained around the edges of the vent with a visible buildup of dust. During an interview on 8/13/24 at 11:44 AM, the Dietary Manager indicated the ceiling was usually wet but had not noticed the paint was loose and peeling. During an interview on 8/14/24 at 11:51 AM, the Maintenance Manager stated he was recently hired. He indicated he did not receive any work orders nor was he notified about the vent dripping water or the paint on the ceiling paint coming loose. The Maintenance Manager stated a few weeks ago the Administrator was discussing a plan for work to be done in the kitchen regarding painting and patching the walls, redoing the floors, and installing a new refrigerator. The Maintenance Manager explained there was no discussion about the ceiling or the vent. The Maintenance Manager stated the dietary staff had the kitchen air conditioning thermostat set at 65 degrees which resulted in the air conditioning equipment running nonstop as it could not reach that temperature. The kitchen was usually hot because of the cooking and the kitchen staff were also keeping the back door open, resulting in increased moisture in the kitchen, causing further condensation on the vent. He indicated the condensation was causing the ceiling to be wet and the paint started to peel. He explained the thermostat setting was changed to 72 degrees on 8/13/24. He said when the thermostat was set at a moderate temperature, the air conditioning would not have to run continuously which would prevent the condensation. The Maintenance	F 921	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: Beginning on 08/13/2024, the administrator educated the Maintenance and Housekeeping Supervisor on the requirement that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The administrator or designee will ensure this information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 09/3/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F921 Quality Assurance Tools weekly x 3 weeks then monthly x 2 months. The Administrator or designee will monitor for compliance with Safe/Functional/Sanitary/Comfortable Environment. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure	

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F 921	Continued From page 37 manager stated on 8/13/24 he had cleaned the vent and patched the ceiling. During a third interview on 8/14/24 at 12: 00 PM, the Dietary Manager stated depending on the outside temperature, the HVAC vent would drip water, especially when there was a lot of humidity outside. The Dietary Manager stated she did not recall the date, but a few months ago she did report to the previous Maintenance Manager about the vent dripping water. The Administrator was also made aware about the vent dripping water and ceiling being wet. The ceiling was repaired previously; however, it had deteriorated a few days ago. The Dietary Manager indicated the vent was cleaned on 8/13/24. During an interview on 8/14/24 at 12:34 PM, the Administrator stated the HVAC vent had condensation due to the thermostat being set at a very low temperature, the air conditioning ran constantly, and there was increased humidity in the kitchen due to staff frequently opening the back door. The buildup of condensation at the HVAC vent resulted in the ceiling being wet. The Administrator indicated the ceiling paint near the vent may have become loose due to the condensation.	F 921	corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/04/2024	