STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

(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 A recertification survey was conducted from 09/09/24 through 09/12/24 The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # KX0Q11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted at this facility from 09/09/24 through 09/12/24. Event ID #KX0Q11.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident, staff, Physician, and Vascular Clinic Nurse interviews, the facility failed to provide Thromboembolic Deterrent (TED) compression stockings and elevation of the lower extremities when up in her wheelchair which were ordered by the Vascular Nurse Practitioner (NP) on 6/5/2024 for 3 months, for a resident with bilateral lower extremity edema (swelling and puffiness of the lower legs and feet as a result of weakness or damage to veins in the legs), (Resident #27), for 1 of 2 residents reviewed for compression stockings.	F 684	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 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. F684	9/19/24

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

Electronically Signed | 09/23/2024

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F 684	Continued From page 1 Findings included: Resident #27 was admitted to the facility on 7/1/2022, with diagnoses to include rheumatoid arthritis, diabetes mellitus type 2 with diabetic neuropathy (nerve damage that causes weakness, numbness, and pain), and atrial fibrillation. A physician's progress note written by Nurse Practitioner (NP #2) dated 1/26/2024 at 12:00 P.M. read in part, "History of present illness: Resident has complaints of bilateral feet turning purple/black when she was sitting in her wheelchair. She stated that the left foot was worse than the right foot. She states that when she is in bed her feet are red and hot." The note further read Resident #27's bilateral feet were beefy red with erythema (redness caused by dilated blood vessels and capillaries) and nursing staff were made aware of referring her to vascular clinic for evaluation and treatment. A physician's order written by NP #2 dated 1/26/2024 was for a referral to vascular clinic due to possible bilateral lower extremity venous insufficiency. A consultation note written by the Vascular Clinic NP on 6/5/2024 read in part that a venous/arterial ultrasound was performed on Resident #27 and revealed that she had moderate peripheral venous insufficiency in her bilateral lower extremities with the left leg being worse than the right. The Vascular Clinic NP orders were for Resident #27 to wear compression garments/stockings during waking hours, elevate legs when sitting and increase exercise as tolerated and she would reassess after 3 months	F 684	The facility failed to provide Thromboembolic Deterrent (TED) compression stockings and elevation of the lower extremities when up in her wheelchair which were ordered by the Vascular Nurse Practitioner on 06/05/2024 for 3 months, for a resident with bilateral lower extremity edema (swelling and puffiness of the lower legs and feet as a result of weakness or damage to veins in the legs), for 1 of 2 residents reviewed for compression stockings. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/10/2024, the Nursing Home Administrator contacted the ordering provider at the Vascular Clinic to discuss the order for compression stockings and the need to be measured for appropriate and ordered stockings. The Vascular Clinic scheduled an appointment for the resident on 09/11/2024. Resident was transported to the Vascular Clinic appointment, clinic measured resident and placed compression stockings on resident, resident then returned with stockings on bilaterally. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 09/19/2024 the Director of Nursing audited all residents with orders present for compression stockings, braces, splints, or any other ordered device to ensure the resident had the appropriate ordered device and the device was in use per provider orders.	

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F 684	Continued From page 2 of conservative management. Resident was to elevate her legs when sitting, compression stockings/garments while awake, and increase exercise, and follow-up in 3 months. The quarterly Minimum Data Set (MDS) assessment dated 7/5/2024 revealed Resident #27 was alert and oriented. A progress note written by NP #1 dated 8/12/2024 at 1:00 PM read in part, that Resident #27's extremities were positive for trace edema. A progress note written by NP #1 on 8/26/2024 at 1:00 PM revealed Resident #27's lower extremities had a trace of edema. A progress note written by Physician's Assistant (PA) on 9/3/2024 at 12:00 PM read in part that Resident #27 was asking questions regarding compression stocking orders that have been ordered for peripheral vascular disease (PVD). A Provider Note written by the Vascular NP at Resident #27's follow-up visit on 9/4/2024, read in part, that Resident #27 was being seen for a 3 month follow-up. Resident was supposed to wear compression garments to bilateral legs, but she was wearing only one on her right leg intermittently with minimal improvement, because there was no compression hose/garment yet for left leg. Resident #27 has significant reflux to the bilateral main superficial veins. Will consider thermal ablation [using heat to seal off varicose veins) if symptoms do not improve with conservative measures. An interview with Resident #27 was completed on 9/9/2024 at 11:30 AM. Resident #27 stated that	F 684	The audit was completed on 09/19/2024. The results were that 100% residents with orders had the appropriate device in place and in use per provider orders. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/18/2024 the Director of Nursing and Staff Development Coordinator began education of all Full Time, Part Time, as needed nurses, nursing assistants, agency nursing assistants, and agency nurses on the use of ordered devices and documentation as appropriate per provider orders to ensure quality of care is met. Any nurse or nursing assistant not educated by 09/20/2024 will not allowed to work until education has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nursing and/or designee to ensure all ordered devices are applied per provider order and documentation present for use as ordered by provider. Audits will be completed weekly x 2 and monthly x 3 or until	

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F 684	Continued From page 3 the physician at the Vascular clinic had written orders for compression garments/stocking to be worn on her legs on 6/5/2024. She further stated that she had just received the compression stockings on 9/4/2024. Resident #27 indicated that when the compression garment had arrived there was only one in the package. Resident #27 stated that she had even called the Vascular Clinic in July 2024 and told them the facility was not applying the compression stockings or elevating her legs. Resident #27 stated she had asked the Director of Nursing (DON) on 7/26/2024 and 8/28/2024 about the compression stockings and he had reported to her that they were ordered. An interview was completed with the Long-Term Care (LTC) Support Nurse on 9/10/2024 at 1:22 PM. The LTC Support Nurse stated that the facility had ordered the compression garments/stockings in June 2024, but only one compression garment was in the package. She further stated that they had placed an order for another compression garment, and they had not received it yet. The LTC Support Nurse indicated the facility had ordered the compression stockings and they were delivered on 9/4/2024. An interview with the Director of Nursing (DON) was conducted on 9/10/2024 at 3:36 PM. The DON stated that the facility had ordered the compression garments/stockings in July and when the package arrived it only contained one compression garment (wrap with Velcro straps that compress the legs). He further stated that he had asked Central Supply to order another one and that it had never arrived. The DON stated that Resident #27 was correct that she had asked him twice about when the compression garments	F 684	resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or designee 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 Quality assurance Meeting is attended by the Administrator, Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/19/2024	

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F 684	Continued From page 4	F 684		

would arrive once in July and again in August. He indicated that on 9/1/2024 the facility had ordered the compression stockings, and they had arrived on 9/4/2024.

An interview with Resident #27 was completed on 9/11/2024 at 9:20 AM. Resident #27 stated the facility had made an appointment for her at the Vascular Clinic today at 10:30 AM for her to get fitted for compression stockings and then they would supply her with the correct compression stockings.

An interview was conducted with the Vascular Clinic Nurse on 9/11/2024 at 10:47 AM. The Vascular Clinic Nurse stated that the Vascular NP was on vacation. She further stated that Resident #27 did call the clinic on 7/22/2024 to express concern that the nursing staff was not applying the compression stockings or elevating her legs as ordered by the Vascular NP. The Vascular Clinic Nurse indicated that the Vascular NP was made aware of the nursing staff not applying the compression stockings.

An interview was conducted with the Central Supply Supervisor on 9/11/2024 at 12:36 PM. The Central Supply Supervisor stated that she had ordered the compression garment when Resident #27 returned from the Vascular Clinic. She further stated that when the facility received the package, there was only one compression garment in the box. The Central Supply Supervisor stated that she had ordered another one on 6/21/2024 but it was still in process, and she didn't know why it was taking so long. She stated that she ordered the items she was instructed by the DON to order. She indicated she ordered the compression stockings for Resident #27 on

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F 684	Continued From page 5	F 684		

9/1/2024 and they received them on 9/4/2024.

An observation and interview with Resident #27 sitting up in wheelchair occurred on 9/11/2024 at 2:25 PM. She was observed sitting up in wheelchair with bilateral compression stockings on and her legs were hanging dependently. Resident #27 stated that her feet were supposed to be elevated, but she didn't have anything to elevate them on. Nurse #9 was also in the room and was trying to attach the leg rests to the wheelchair. Nurse #9 stated that the leg rests did not fit Resident #27's wheelchair, and she would get someone from therapy to look at it.

A progress note written by the Physical Therapist (PT) on 9/11/2024 at 2:57 PM revealed he was consulted to see Resident #27's wheelchair regarding the wrong footrests for the chair. The note further read that he had provided Resident #27 with a new wheelchair with elevating footrests on 9/11/2024. It further read that her legs were elevated to resident's tolerance and nursing staff were educated on how to elevate and lower leg rests as needed for the resident.

A telephone interview was conducted with the Medical Director on 9/12/2024 at 10:02 AM. The Medical Director stated she referred Resident #27 to the Vascular Clinic because of the swelling in her legs. She further stated that if the Vascular Clinic NP had ordered compression stockings, she would expect the facility to get them in a week or so. The Medical Director stated that almost 3 months was not an acceptable amount of time to receive the compression stockings. She indicated that the compression stockings were ordered for the swelling and the purpose of the compression stockings were prevent excessive

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F 684	Continued From page 6 fluid buildup in the lower extremities, and to prevent complications such as weeping (fluid leaks out of the tissues onto the skin) and venous stasis ulcers. The Medical Director stated that the compression stockings for Resident #27 was a physician's order and she expected the orders to be followed. An observation and interview were completed on 9/12/2024 at 10:14 AM. Resident #27 was lying in bed without the compression stockings on her legs, her feet were noted to be red and edematous. Resident #27 stated that her feet were hurting her this morning and that she probably should be wearing her compression stockings, but she was waiting until after she received her shower to have the staff apply them. An interview was completed with the DON on 9/12/2024 at 10:44 AM. The DON stated the nursing staff should have followed the physician's orders and had the compression stockings in a timely manner. He further stated that he could not answer as to why it took so long for the compression stockings to be ordered and received, except there was a breakdown somewhere in the ordering process. The DON indicated that Resident #27 should have been provided with a wheelchair with footrests that could have been elevated when she was up in her chair.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		9/19/24

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F 756	Continued From page 7 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, and staff interviews, the facility failed to act on a pharmacy recommendation to complete an Abnormal Involuntary Movement Scale	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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F 756	Continued From page 8 (AIMS/discus) assessment for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for psychotropic medications, Resident #57. Findings included: Resident #57 was admitted to the facility on 03/23/20 with diagnoses that included schizophrenia, anxiety and major depression. Review of the physician orders on 09/10/24 for Resident #57 revealed an order for Risperdal M-Tab tablet Dispersible 0.5 MG (Milligrams) give one tablet by mouth at bedtime related to recurrent major depressive disorder and moderate schizophrenia unspecified. Place on tongue and let dissolve (Order start date 09/25/23). A quarterly Minimum Data Set (MDS) assessment dated 07/09/24 for Resident #57 was reviewed. Resident #57 had intact cognition. He had no moods or behaviors. He had no hallucinations or delusions. He had no extremity mobility impairments. He had received the following medications during the look back period: Antipsychotic, antidepressant, diuretic and opioid. Antipsychotic medication was received on a routine basis only. The care plan completed on 09/09/24 for Resident #57 included the following focus area: Receives antipsychotic medication with a risk for adverse side effects and diagnoses of major depressive disorder and schizophrenia. The goal was for Resident 57's risk for adverse reactions related to the used of antipsychotic medication to be minimized through current interventions for 90	F 756	To remain in compliance with all 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. F756 The facility failed to act on a pharmacy recommendation to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident who received an antipsychotic medication for 1 of 5 residents reviewed for psychotropic medications. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/10/2024, the Director of Nursing performed an Abnormal Involuntary Movement Scale (AIMS) assessment on the identified resident. AIMS assessment did not reveal any new findings that differ from the last AIMS assessment and remains low risk for movements and to continue to monitor per policy. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 09/19/2024 the Director of Nursing audited all residents with on anti-psychotic medications to ensure an AIMS assessment has been completed within 6 months or for a new order of an anti-psychotic medication. This was completed on 09/19/2024. The	

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F 756	Continued From page 9 days. Interventions included, in part, to administer medication as ordered by the physician; report any of the following to the nurse immediately if noted: involuntary movements, nausea/vomiting, palpitations, chest pain, change in balance and coordination, muscle rigidity, or restlessness; and report sedation or change in mental functioning if noted. Review of the medical record on 09/10/24 for Resident #57 revealed an AIMS/discus assessment was last completed ten months prior on 11/01/23. The result of the assessment revealed he was at a low risk for a movement disorder and to continue to monitor according to the policy. Review of a Consultant Pharmacist's Medication Regimen Review dated 07/15/24 documented Resident #57 was due for an AIMS/discus assessment related to the use of the antipsychotic medication Risperdal. The recommendation was signed as acted upon by Unit Manager #1 but not dated. In an interview with the Interim Director of Nursing on 09/10/24 at 2:15 PM he explained when a pharmacy report was received from the pharmacist, he gave the recommendations to Unit Manager #1 to review and take the appropriate actions. He stated he failed to review the resident's record after the report was returned to him from Unit Manager #1 to ensure any needed recommended actions had been taken. He stated it was ultimately his responsibility to ensure the pharmacy recommendations were addressed. In an interview with Unit Manager #1 on 09/10/24	F 756	results were that 2 of 13 residents needed a current AIMS assessment. On 09/19/2024 the 2 identified residents had an AIMS assessment completed by the licensed nurse with Low Risk for movements noted and to continue to monitor per policy. All other 11 residents noted to have up to date AIMS assessments completed. On 09/12/2024 the Director of Nursing began reviewing past 6 months of pharmacy recommendations to ensure recommendations have been reviewed and acted upon if indicated. The audit completed on 09/18/2024. The results were that pharmacy recommendations have been given to the provider for further action if indicated for provider review. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/18/2024 the Director of Nursing began a new process in which the Administration nurses will complete AIMS assessments going forward. Administration nurses will discuss the need for AIMS assessments during daily clinical and complete as needed per policy. Pharmacy recommendations will be reviewed by the Director of Nursing and discussed at daily clinical to monitor for any new recommendations. On 09/18/2024 the Director of Nursing and Staff Development Coordinator began education to the Administration nurses to include the LPN Support Nurses, Unit Managers, and MDS coordinator to ensure that AIMS assessments are	

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F 756	Continued From page 10 at 2:37 PM she confirmed that she had signed off on the pharmacy report that the AIMS/discus assessment for Resident #57 had been completed as recommended by the pharmacist. She stated she had delegated the task to another nurse but had failed to double check and make sure the task had been completed. She stated it was her full responsibility to make sure the assessment had been completed and that she should have completed the assessment herself but had not. In an interview with the Administrator on 09/10/24 at 2:05 PM she stated she expected all residents receiving psychotropic medications to have an AIMS assessment completed every six months. She noted Resident #57 had an AIM/discus assessment done last in November of 2023 and an assessment had not been completed within the last six months as expected. In an interview with the Consulting Pharmacist on 09/11/24 at 3:15 PM she stated she had notified the facility in July that an AIMS/discus assessment for Resident #57 was due for Risperdal use, an antipsychotic. She explained that a resident on an antipsychotic medication should have an assessment completed every six months to determine if there were any side effects from the medication.	F 756	complete minimum of every 6 months, upon admission/readmission, and/or when a new antipsychotic medication is ordered and policy being followed. This education was completed on 09/18/2024. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nursing and/or designee to ensure that AIMS assessments are completed minimum of every 6 months, upon admission/readmission, and/or when a new antipsychotic medication is ordered by discussing in daily clinical review. Quality assurance audits will be completed by the Director of Nursing and/or designee to ensure that pharmacy recommendations are reviewed timely in daily clinical review and given to the provider as applicable. Audits will be completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or designee 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 Quality assurance Meeting is attended by the Administrator,	

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	345054	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 11	F 756	Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/19/2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		9/19/24

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F 761	Continued From page 12 by: Based on observations, record reviews, and staff interviews, the facility failed to discard expired opened multidose medications, date an opened multidose medication and dispose of loose unidentifiable pills in the drawer of the medication cart (1100 Long Hall) and failed to discard an opened multidose medication per manufacturer's instructions stored for use in the medication cart (Memory Care Unit) for 2 of 6 medication carts reviewed. And the facility failed to remove expired medications available for use in the automated medications dispensing machine in 1 of 4 medication rooms (the Rehab Unit) reviewed for medication storage. Findings included: 1) Observation of the 1100 Long Hall medication cart was conducted on 9/9/2024 at 10:47 AM in the presence of Nurse #9 revealed the following medications were stored on the medication cart: 1a. According to the product manufacturer's instructions, in-use Humalog prefilled insulin KwikPen should be stored at room temperature of less than 86 degrees Fahrenheit (F) and used within 28 days. Resident #25's Humalog prefilled insulin KwikPen was labeled with the opened date of 8/7/2024 and should have been disposed of on 9/4/2024. According to the product manufacturer's instructions, in-use Incruse Ellipta inhaler should be disposed of 6 weeks after opening. Resident #74's Incruse Ellipta inhaler was labeled with the opened date of 7/1/2024 and should have been disposed of on 8/12/2024.	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 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 761 The facility failed to discard expired opened multidose medications, date an opened multidose medication and dispose of loose unidentifiable pills in the drawer of the medication cart (1100 hall) and failed to discard opened multidose medication per manufacturer□s instructions stored for us in the medication cart (Memory Care) for 2 of 6 medication carts reviewed. And the facility failed to remove expired medications available for use in the automated medication dispensing machine 1 of 4 medication rooms (Rehab Unit) reviewed for medication storage. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/09/2024 the LPN Support Nurse removed Resident #25□s Humalog prefilled insulin Kwikpen was labeled with the opened date of 8/7/24 that was to be discarded of on 09/04/2024 located on the	

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F 761	Continued From page 13 According to the product manufacturer's instructions, in-use Timolol Maleate Opthalmic 0.5% Solution should be discarded 28 days after opening. Resident #68's Timolol Maleate Ophthalmic 0.5% Solution was labeled with the opened date of 8/5/2024 and should have been discarded on 9/2/2024. 1.b Resident #1's opened in-use albuterol sulfate 90 microgram (mcg) inhaler was not labeled with an opened date. 1.c Seven unidentifiable pills of different colors and shapes were observed in the bottom of the drawer of the medication cart. An interview was completed with Nurse #9 on 9/9/2024 at 11:00 AM. Nurse #9 stated that there should not have been any pills loose in the drawers of the medication cart. She further stated there should not have been any expired medications on the cart. Nurse #9 indicated that all opened multi-dose medications should have a date opened label on them. She stated it was the nurse's responsibility to check for expired medications and loose pills on the medication cart. She further stated that she had not had a chance to check her medication cart that morning. An interview was conducted with the Director of Nursing (DON) on 9/12/2024 at 10:45 AM. The DON stated it was the facilities responsibility to ensure that medications were stored according to manufacturer's instructions and to discard expired medications. He further stated there were not supposed to be any loose pills in the	F 761	1100 medication cart. On 09/09/2024 the LPN Support nurse removed Resident #74□s Incruse Ellipta inhaler with opened date of 07/01/2024 that was to be discarded on 08/12/2024 located on the 1100 medication cart. On 09/09/2024 the LPN Support Nurse removed Resident #68□s Timolol Maleate Opthalmic 0.5% solution labeled with open date of 08/05/2024 that was to be discarded on 9/2/24 located on the 1100 medication cart. On 09/09/2024 the LPN Support Nurse removed Resident #1□s opened in-use albuterol sulfate 90 microgram inhaler that did not have an opened date of the 1100 medication cart. On 09/09/2024 the LPN Support Nurse removed the seven unidentifiable polls of different colors and shapes that were observed in the bottom of the drawer of the 1100 medication cart. On 09/10/2024 the Director of Nursing removed the open box of Ipratropium Bromide 0.02% nebulizer solution vials in foil packages with opened date of 09/01/2024 that was to be discarded on 09/08/2024 located on the Memory Care medication cart. On 09/10/2024 the Director of Nursing removed the Novolin 70/30 insulin FlexPen with expiration date of 08/31/2024 and an Aspart insulin Flexpen with an expiration date of 05/31/2024 from the Rehab automated medication dispensing machine. 2.Corrective action for residents with the potential to be affected by the alleged	

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F 761	Continued From page 14 medication cart drawers. 2) An observation was conducted on 9/10/2024 at 12:43 PM of the Memory Care unit medication cart in the presence of Nurse #8. The observation revealed an open box of Ipratropium Bromide 0.02% nebulizer solution vials in foil packages. According to the manufacturer's instructions the individual vials are to be disposed of 7 days after opening. The date on the opened foil package was 9/1/2024 and it should have been disposed of 9/8/2024. An interview with Nurse #8 was completed on 9/10/2024 at 12:55 PM. Nurse #8 stated that there should not be any expired medications on the medication cart. She further stated that she had checked the medication cart for expired medications that morning, but she must have just missed the opened package of Ipratropium Bromide vials. An interview with the DON was completed on 9/12/2024 at 10:45 AM. The DON stated that it was the nurse's responsibility to check the medication cart for expired medications and to remove them from the cart. 3) An observation of the Rehab Unit Medication Storage room was completed on 9/10/2024 at 1:50 PM in the presence of the Rehab Nurse Manager. An observation of the automated medication dispensing machine refrigerator revealed a Novolin 70/30 insulin FlexPen with the expiration date of 8/31/2024, and an Aspart insulin FlexPen with an expiration date of 5/31/2024 were available for use. An interview with the Rehab Nurse Manager	F 761	deficient practice. On 09/12/2024 the Director of Nursing/LPN Support Nurses audited all medication carts to ensure that all insulin pens are dated with open date and not expired with 28 days per manufacturer guidelines, inhalers are labeled with open date and not expired with 28 days per manufacturer guidelines, ophthalmic solutions are labeled with open date and not expired with 28 days per manufacturer guidelines, opened foil packs of nebulizer solutions have opened date and not expired in 7 days per manufacturer guidelines, and no loose unidentifiable pills in medication carts. On 09/12/2024 the Director of Nursing audited the automated medication dispensing machine to ensure no expired medications to include medications locked in the dispensing medication refrigerator. Audits were completed on 09/12/2024. The results included: 1100 unit medication carts, 1200 unit medication carts, Memory Care medication cart, Rehab medication cart, and automated medication dispensing machine had no expired medications; all inhalers, insulin pens, ophthalmic solutions, and nebulizer solutions were labeled with the opened date and remain in the window of use per manufacturer guidelines; no medication cart had unidentifiable loose pills noted. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/18/2024 the Director of Nursing and Staff Development Coordinator began	

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F 761	Continued From page 15 occurred on 9/10/2024 at 1:50 PM. The Rehab Nurse Manager stated that she was not sure who was responsible for removing expired medications from the automated medication dispensing machine. She further stated that a pharmacy consultant came to the facility every month and checked the medication carts and medication storage rooms. An interview with the DON was completed on 9/10/2024 at 2:07 PM. The DON stated it was his responsibility to check the automated medication dispensing machine refrigerator for expired medications. He further stated there should not have been expired insulin in the machine available for use. The DON indicated that the staff needed to be more aware of expiration dates and follow the manufacturer's instructions for storage of medication.	F 761	education of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included safely securing and storing medications, labeling of the date on opened insulin pens and checking expiration dates on medications to assure no expired medications are administered. Any nurse or medication aide not educated by 09/20/2024 will not allowed to work until education has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nursing and/or designee for F761 Adequate Label/Store Drugs and Biologicals to assess that all medications are safely and appropriately stored, that all opened insulin pens are dated and no expired insulin pens are on the medication cart. Audits of medication carts to ensure locked, no loose unidentifiable pills, safe storage of medications, appropriate dating of insulin pens, oral inhaler vial solutions, nebulizer solutions, and ophthalmic solutions are dated, stored and disposed	

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F 761	Continued From page 16	F 761	of per manufacturers guidelines will be completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or designee 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 Quality assurance Meeting is attended by the Administrator, Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 09/19/2024	