STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HICKORY	3031 TATE BOULEVARD SE HICKORY, NC 28602

(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 and complaint investigation was conducted on 11/12/24 through 11/15/24. The facility was found in compliance with the requirment CFR 483.73. Emergency Preparedness Event ID #LU7I11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigtion survey were conducted from 11/12/24 through 11/15/24. Event ID: LU7I11. The following intake was investigated: NC00222895. 1 of 1 allegation did not result in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of opioid medications and bowel continence for 2 of 2 residents reviewed for Preadmission Screening and Resident Review (PASRR) (Resident #65 and Resident #67). The findings included: 1. Resident #65 was admitted to the facility on 02/06/24 with diagnoses that included chronic pain A review of Resident #65's most recent quarterly Minimum Data Set assessment dated 09/05/24 revealed she was cognitively intact. Resident #65	F 641	On 11/13/24 review of most recent MDS assessment dated 9/5/24 for resident #65 was not coded for opioid medication during the assessment lookback period. Resident #67 was not coded for Bowel Continence on the most recent MDS assessment dated 08/12/24. On 11/13/24 both MDS Assessments for residents #65 and #67 dated 09/05/24 and 08/12/24 were modified and submitted by MDS Nurse. On 11/20/24 Regional MDS Nurse Consultant educated both MDS Nurse on accuracy of Comprehensive MDS Assessments. This education was	11/21/24

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

Electronically Signed | 12/05/2024

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F 641	Continued From page 1 was not coded as taking any opioid medications during the assessment lookback period (7 days ending on the assessment date). A review of Resident #65's physician orders dated 3/15/24 included the following: [hydrocodone-acetaminophen] (an opioid analgesic medication) 7.5 - 325 milligrams (mg) - Give one tablet by mouth, two times a day for pain. A review of Resident #65's August and September 2024 medication administration records revealed Resident #65 received opioid pain medication two times per day during the assessment lookback period. A review of Resident #65's care plan, last reviewed on 09/13/24, revealed a care plan for the following area: [Resident #65] is at risk for developing complications secondary to ...opioid medication [use]. Interventions included to monitor for effectiveness of medication among others. An interview with Resident #65 on 11/13/24 at 12:14 PM revealed she occasionally had some pain and that she did take pain medication that helped control the pain. She indicated she was unsure what the pain medication she took was called. During an interview with MDS Nurse #2 on 11/15/24 at 10:23 AM, she reported she had noted that Resident #65 was on receiving opioid medications and that it should have been accurately coded in her quarterly MDS assessment dated 09/05/24. MDS Nurse #2 reported she must have just mis-clicked the box.	F 641	completed on 11/20/24 and all education will be provided to newly hired MDS staff by Regional MDS Nurse. On 11/20/24 100% Audit section N and H was completed by MDS Nurse to ensure all coded correctly on MDS Assessment for all current residents. Any needed modification to Comprehensive MDS Assessments were made by MDS Nurse on 11/20/24 11/18/2024 Director of Nursing, MDS Nurse or Designee will audit 10 Comprehensive MDS Assessments for accuracy in the areas of Section N and H weekly x 6 weeks, and then will audit 10 Comprehensive MDS Assessments monthly for 4 months for accurate Assessments in Section N & H. During monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for Comprehensive MDS Assessments	

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F 641	Continued From page 2	F 641		

During an interview with the Director of Nursing on 11/15/24 at 10:53 AM, she reported MDS assessments should be completed accurately and indicated if Resident #65 was taking opioid medications, it should have been correctly coded on her quarterly MDS assessment dated 09/05/24.

During an interview with the Administrator on 11/15/24 at 11:47 AM she stated MDS assessments should accurately reflect the individual resident and the medications they take. She stated she expected MDS assessments to be accurate and complete.

2. Resident #67 was admitted to the facility on 03/07/23 with diagnoses that included fracture of left femur.

A review of Resident #67's significant change in status MDS assessment dated 08/12/24 revealed he had moderate cognitive impairment. Resident #67's bowel continence was coded as "not rated".

Review of Resident #67's bowel movement records from 08/06/24 through 08/12/24 which would be the MDS assessment lookback period revealed he had 10 bowel movements over those 7 days and was noted as being incontinent.

During an interview with MDS Nurse #1 on 11/15/24 at 10:20 AM she revealed if a resident was coded as "not rated" for bowel continence on the Minimum Data Set assessment, it would indicate that they either had an ostomy or had not had a bowel movement during the assessment lookback period. She indicated she was aware that Resident #67 did not have an ostomy. After

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F 641	Continued From page 3 she reviewed Resident #67's record, she noted he had multiple bowel movements documented during the lookback period. She stated she should have coded Resident #67's bowel continence as always incontinent based on the information in the medical record. MDS Nurse #1 surmised that she must have mis-clicked "not rated". During an interview with the Director of Nursing on 11/15/24 at 10:53 AM, she reported Minimum Data Set assessments should be completed accurately and indicated if Resident #67 was incontinent of bowel, it should have been correctly coded on the Minimum Data Set assessment dated 08/12/24. During an interview with the Administrator on 11/15/24 at 11:47 AM she stated Minimum Data Set assessments should accurately reflect the individual resident and their continence status. She stated she expected Minimum Data Set assessments to be accurate and complete.	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff	F 695	11/12/24 unit manager signed off on Tar	11/21/24

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F 695	Continued From page 4	F 695		

and Resident interviews, the facility failed to ensure supplemental oxygen was delivered at the physician prescribed rate for 1 of 1 resident reviewed for respiratory care (Resident #61).

The finding included:

Resident #61 was admitted to the facility on 08/18/21 with diagnoses that included coronary artery disease, heart failure and chronic obstructive pulmonary disease (COPD).

A review of Resident #61's physician orders indicated an order dated 01/03/24 for supplemental oxygen to be delivered continuously at 2 liters per minute.

A review of Resident #61's care plan revised 07/12/24 revealed a diagnosis of COPD which required oxygen therapy with a goal that the Resident would show no signs and symptoms of poor oxygenation. The interventions included delivering supplemental oxygen at the prescribed rate of 2 liters per minute via nasal cannula.

The quarterly Minimum Data Set (MDS) assessment dated 10/02/24 revealed Resident #61's cognition was moderately impaired, and she received oxygen therapy. The MDS also indicated the Resident required substantial to maximal assist for turning side to side while in the bed.

On 11/12/24 at 12:21 PM an observation and interview made with Resident #61 revealed she was lying in bed on her back wearing supplemental oxygen delivered through a nasal cannula. The oxygen concentrator was positioned at the foot of the bed with the gage facing the

for the o2 settings for residents #61 she only verified that the bag and tubing had been changed.

11-13-24 Assistant Director of Nursing clarified order with NP for resident # 61 on 02 settings were to remain at 2 liters.

11-13-24 100% Education for all license nurses by ADON on verifying o2 settings are per md order prior to signing off on TAR. All education will provided to newly hired and or/contracted staff upon the start of work By DON, ADON,SDC or Designee.

11-13-24 100% Audit was completed on all residents on oxygen, by ADON and Unit Manager to ensure that oxygen settings are correct, And being administrated per MD order.

DON/ADON or Designee will audit to ensure that oxygen settings are correct And being administrated per MD order 10 Residents a week x 6 weeks then 10 residents a month X 3 months.

During the monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible for reporting cumulative results of monitoring for facility compliance oxygen settings.

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F 695	Continued From page 5	F 695		

bed. The concentrator was rolled outward to reveal the oxygen was set to deliver 4 liters per minute. Resident #61 remarked she stayed in the bed most of the time unless she went to a doctor's appointment. She stated she did not know how much oxygen she was supposed the be receiving and that she did not "mess" with the concentrator setting nor could she reach it.

An observation was made on 11/13/24 at 08:59 AM of Resident #61's oxygen concentrator which was set to deliver 4 liters per minute. The concentrator was positioned at the foot of the Resident's bed with the gauge facing the bed.

At 11:46 AM on 11/13/24 during an observation of Resident #61's oxygen concentrator the setting remained at 4 liters per minute. The Resident again remarked she could not reach the dial on the oxygen concentrator and did not know what the machine should be set on.

An interview was conducted with Nurse #1 on 11/13/24 at 2:12 PM. The Nurse explained that she was responsible for Resident #61 on 11/12/24 and 11/13/24 day shift (7 AM - 3 PM) but had not checked the oxygen concentrator setting yet that day. Nurse #1 reviewed the order for the oxygen which was for 2 liters per minute then went to Resident #61's room to find the oxygen concentrator was set on 4 liters and adjusted the flow back to 2 liters per minute. Nurse #1 explained she could not remember if she had checked the oxygen concentrator setting the day prior (11/12/24) during her shift then checked the Resident's Treatment Administrator Record (TAR) to find that Unit Manager (UM) #1 had checked the TAR on 11/12/24 day shift for the correct setting.

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F 695	Continued From page 6 An interview was conducted on 11/13/24 at 2:24 PM with Unit Manager #1 who explained that she did initial Resident #61's TAR on 11/12/24 for the correct setting but admitted that when she looked at the oxygen concentrator she only looked to see if the tubing and bag had been changed and dated within the correct timeframe. Attempts were made to interview Nurse #2 who initialed Resident #61's TAR for the correct setting of 2 liters on 11/12/24 evening and night shifts but the attempts were unsuccessful. During interviews with the Director of Nursing (DON) on 11/13/24 at 3:13 PM and 11/15/24 at 9:54 AM she explained that the nurses were responsible for checking the oxygen concentrator for the correct setting every shift and initialing the TAR when the procedure was completed. The DON stated she learned on 11/14/24 from a staff member that Resident #61 would use her bed remote to lower her bed then use her Reacher to adjust the knob on the oxygen concentrator to the setting she desired. When the DON was asked why the facility had not identified that as a problem and care planned the situation to monitor her more frequently, the DON replied, "we should have." An interview was conducted with the Administrator on 11/15/24 at 10:40 AM who explained that her expectation was for the nurses to monitor the oxygen setting as ordered and not initial off the TAR until the procedure was completed.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		11/21/24

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F 756	Continued From page 7	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(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.

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F 756	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendation to add side effect monitoring to an antipsychotic medication (used to treat mental disorders) for 1 of 5 residents (Resident #96) reviewed for unnecessary medications. The finding included: Resident #96 was admitted to the facility on 06/23/24 with diagnoses that included schizophrenia. A review of a significant change Minimum Data Set (MDS) assessment dated 07/15/24 revealed Resident #96 had intact cognition and received an antipsychotic medication. A review of Resident #96's physician orders revealed orders for - risperidone 2 milligrams (mg) by mouth twice a day for schizophrenia dated 07/02/24. - risperidone 2 mg by mouth once a day in the morning and 3 mg once a day at bedtime for schizophrenia dated 08/08/24. - risperidone 3 mg by mouth twice a day for schizophrenia dated 08/30/24. A review of a Pharmacy report dated 08/16/24 revealed a suggestion to add side effects and behavior monitoring to the antipsychotic medication (risperidone). Reviews of the Medication Administration Records (MAR) for 07/2024, 08/2024, 09/2024, 10/2024 and 11/2024 revealed there were no	F 756	Pharmacy report dated 8/16/24. Suggested to add side effects and behavioral monitoring to anti-psychotic medication. Reviews of the medication administration record. 7/24. 8/24. 9/24, 10/24 and 11/24 were revealed. There were no directions to monitor for side effects and behaviors for antipsychotic medication on Mars. 11-13-24 Director of Nursing audited the last 3 months of Pharmacy recommendation to ensure that all recommendation have been followed or reviewed by provider. 11-13-24 Education given to DON by Administrator That all pharmacy recommendation will be completed timely. 11-15-24 DON/ADON will audit 10 pharmacy recommendations weekly x 6 weeks for completions of recommendation. During monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for psychoactive monitoring	

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F 756	Continued From page 9 directions to monitor for side effects and behaviors for the antipsychotic medication on the MARs. An interview was conducted on 11/14/24 at 9:36 AM with the Pharmacy Consultant who explained that she routinely pulled a report about every other month to ensure that all psychoactive medications have monitoring instructions for the medications. She acknowledged that she notified the facility to add the monitoring of behaviors and side effects to Resident #96's antipsychotic order on her 08/16/24 report and stated she would follow up on her request this month during her next review because her schedule had to be adjusted because of the recent hurricane. The Pharmacist indicated that it was her expectation for the facility to have added the monitoring before her next medication regimen review. During an interview with the Director of Nursing (DON) on 11/14/24 at 9:49 AM the DON stated she was aware of the Consultant Pharmacist's request to add the monitoring instructions to Resident #96's antipsychotic medication, but it just slipped by her and it should have been done because she has had ample time to do it. An interview was conducted with the Administrator on 11/15/24 at 10:36 AM who explained that she expected the staff to address the Pharmacy recommendations when they were provided to the facility.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		11/21/24

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F 758	Continued From page 10	F 758		

affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 11 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Consultant Pharmacist interviews, the facility failed to identify the lack of monitoring for side effects and behaviors for an antipsychotic medication (used to treat mental disorders) for 1 of 5 residents reviewed for unnecessary medications (Resident #96). The finding included: Resident #96 was admitted to the facility on 06/23/24 with diagnoses that included schizophrenia. A review of a significant change Minimum Data Set (MDS) assessment dated 07/15/24 revealed Resident #96 had intact cognition and received an antipsychotic medication. A review of Resident #96's physician orders revealed orders for - risperidone 2 milligrams (mg) by mouth twice a day for schizophrenia dated 07/02/24. - risperidone 2 mg by mouth once a day in the morning and 3 mg once a day at bedtime for schizophrenia dated 08/08/24. - risperidone 3 mg by mouth twice a day for schizophrenia dated 08/30/24. A review of a Pharmacy report dated 08/16/24 revealed a suggestion to add side effects and	F 758	Review of Medication Administration records for 7/24-8/24,9/24,10/24 11/24 revealed there were no Directions to monitor for side effects and behaviors for antipsychotic medication on the MAR for resident #96. 11-13-24 Resident #96. A Behavior monitoring order was added by the Unit Manager. 11/15/2024 100% educated all licensed nurses that all residents on psychoactive Medications have side effects and behavior monitoring in place. Education was done by ADON. All education will be provided to newly hired and or/contracted staff upon the start of work. 11-15-24 100% audit of all residents On Psychoactive Medication was completed by DON/ADON And unit managers to ensure they have monitoring order. DON/ADON/UNIT MANAGER or designee will audit 5x a week the order listing report to review any new orders for Psychoactive Medications to ensure that behavior monitoring is in place, for 6 weeks. Then Monthly for three months.	

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F 758	Continued From page 12 behavior monitoring to the antipsychotic medication (risperidone). Reviews of the Medication Administration Records (MAR) for 07/2024, 08/2024, 09/2024, 10/2024 and 11/2024 revealed there were no directions to monitor for side effects and behaviors for the antipsychotic medication on the MARs. On 11/13/24 at 3:38 PM during an interview with Nurse #1, she confirmed she was Resident #96's full time Nurse on first shift. The Nurse explained that the admitting nurse was responsible for putting the monitoring directions for the psychoactive medications on the MARs. Nurse #1 reviewed Resident #96's last three monthly MARs and acknowledged there were no behavioral or side effects monitoring on the MARs and stated, "oh well, I guess that was my fault." An interview was conducted on 11/14/24 at 9:36 AM with the Pharmacy Consultant who explained that she routinely pulled a report about every other month to ensure that all psychoactive medications have monitoring instructions for the medications. She acknowledged that she notified the facility to add the monitoring of behaviors and side effects to Resident #96's antipsychotic order on her 08/16/24 report and stated she would follow up on her request this month during her next review. She indicated she would have pulled another report during her October visit, but her schedule had to be readjusted for her reviews at the facilities because of the hurricane and had not been able to review the facility's medication regimen for this month yet but indicated that her expectation was for the facility to have added the monitoring before her next review.	F 758	During monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for psychoactive medication.	

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F 758	Continued From page 13 During an interview with the Director of Nursing (DON) on 11/14/24 at 9:49 AM the DON explained that the unit managers and the nurses were responsible for adding the monitoring instructions to the psychoactive medications. The DON stated she was aware of the Consultant Pharmacist's request to add the monitoring instructions to Resident #96's antipsychotic medication, but it just slipped by her and it should have been done because she has had ample time to do it. An interview was conducted with the Administrator on 11/15/24 at 10:36 AM who explained that she expected the staff to address the Pharmacy recommendations when they were provided to the facility.	F 758		
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	F 761		11/21/24

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F 761	Continued From page 14 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 and staff interviews the facility failed to remove expired medications and intravenous fluids stored for use in 3 of 4 medication storage rooms (East, North, and Memory Care) reviewed for medication storage. The findings included: a. An observation was conducted on 11/12/2024 at 11:34 am of the East Medication Storage Room. The East Medication Storage Room contained 3 syringes of Heparin (blood thinning medication) that expired 2/2022, 2 syringes of Heparin that expired 3/31/2022, 2 syringes of Heparin that expired 4/30/2022, 8 syringes of Heparin that expired 6/30/2022, 2 syringes of Heparin that expired on 7/31/2022, 1 syringe of Heparin that expired on 8/31/2022, 10 syringes of Heparin that expired on 11/30/2022, 21 syringes of Heparin that expired 3/2023, 9 syringes of Heparin that expired 7/31/2023, 14 syringes of Heparin that expired 8/2023, 4 syringes of Heparin that expired 3/31/2024, 2 syringes of Heparin that expired 5/2024, 3 syringes of Heparin that expired 6/2024, and 1 syringe of Heparin that expired on 7/2024. b. An observation was conducted on 11/12/2024 at 12:42 pm of the North Medication Storage	F 761	Based on observation. The facility failed to remove expired medication and intravenous fluids stored for use in three or four medication rooms, East, North, and Memory Care. Review for medication storage. 11/13/2024 DON/ADON/Unit Manager and Pharmacy audited all medication rooms and Med carts. To ensure all expired medications and fluids were removed. 11-13-24 ADON began 100% In servicing of all licensed nurses and Med Aides on Medication Storage to ensure no expired medication on the carts or in the medication rooms. All education will be provided to newly hired and or/contracted staff upon the start of work. Beginning on 11/18/2024. DON/ADON. Or designee Will, audit all medication carts, treatment carts and Med rooms three times a week for six weeks. monthly x three months to ensure there is no expired medication on carts or medication rooms.	

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F 761	Continued From page 15 Room. The North Medication Storage room contained 3 bags of 0.45% Normal Saline that expired 8/2024. c. An observation was conducted on 11/12/2024 at 2:28 pm of the Memory Care Unit Medication Storage Room. The Memory Care Unit Storage Room contained 2 syringes of Heparin that expired on 4/20/2024, 7 syringes of Heparin that expired on 5/2024, 1 bag of Normal Saline 250 ml that expired 5/2024, 2 syringes of Heparin that expired on 6/2024, 3 syringes of Heparin that expired on 7/2024, 19 syringes of Heparin that expired on 8/2024, and 4 syringes of Heparin that expired 9/2024. An interview was conducted on 11/12/2024 at 2:30 pm with the Assistant Director of Nursing (ADON). The ADON stated she audited all the medication carts and medication storage rooms recently and there were not any expired medications at that time. An interview was conducted on 11/14/2024 at 12:14 pm with the Unit Manager. The Unit Manager stated she and the ADON were responsible for checking to ensure there were no expired medications on the medication carts or in the medication storage rooms. The Unit Manager stated medication carts are checked daily and medication storage rooms are checked weekly. The Unit Manager stated she was not sure why there were expired medications in the medication storage rooms. A follow-up interview was conducted on 11/14/2024 at 2:45 pm with the ADON. The ADON stated she had audited the medication carts, uncertain about medication storage rooms,	F 761	During monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for Medication Storage.	

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F 761	Continued From page 16 11/8/2024. The ADON stated when she checked medication carts, she checked opened insulin pens to ensure they were not expired, checked expiration dates on other medications, and check to ensure medications on the cart were prescribed. The ADON stated when the medication storage rooms were checked, she checked for the same things. The ADON stated she had never looked in the drawers where the Heparin was stored. An interview was conducted on 11/14/2024 at 3:03 pm with the Director of Nursing (DON). The DON stated the ADON should have checked for expired medications and supplies at least weekly. The DON stated the facility had not followed the medication storage process.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		11/21/24

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providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 18 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to implement their policy for handwashing/hygiene when Nurse Aide (NA) #1 failed to sanitize her hands after removing soiled gloves during incontinent care. The facility also failed to handle soiled linen in a manner to prevent the spread of infection when Nurse Aide #2 threw soiled linen on the floor after providing incontinent care. This occurred for 2 of 2 staff members observed for infection control practices (NA #1 and NA #2). The findings included: A review of the facility's policy for Handwashing/Hand Hygiene revised October 2023 revealed the facility considered hand hygiene to be the primary means to prevent the spread of healthcare-associated infections. 1. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors. Indications for Hand Hygiene: c. after contact with blood, body fluids, or contaminated surfaces; f. before moving from work on a soiled body site to a clean body site on the same resident, and g. immediately after glove removal. A review of the facility's policy for Making an Occupied Bed revised October 2010 revealed 4.	F 880	CNA #1 failed to sanitize her hands after removing soiled gloves during incontinent care. Also, CNA #2 threw soiled linen on the floor after providing incontinent care. This occurred for two of two staff members. 11/18/24 CNA #1 and CNA #2 have both had their competency validated for infection control to include hand hygiene after removing soiled gloves and proper discard of soiled linen by SDC. 11/18/24 100% Inservice for all direct care staff on handling of soiled linen and hand hygiene by ADON. All education will be provided to newly hired and or/contracted staff upon the start of work. 11/18/2024. DON/ADON or designee Will observe hand hygiene and handling of soiled linen, during Resident Care on 10 residents a week for six weeks, then 10 residents a month for 3 months. To ensure hand hygiene is performed prior and between glove donning. Also, that linen is appropriately bagged and handled out of the room. During monthly Quality Assurance &	

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F 880	Continued From page 19 Do not put soiled linen on the floor. As you remove it, place it into the container you are using for soiled laundry/linen. On 11/14/24 at 3:02 PM to 3:45 PM a continuous observation was made of Nurse Aide (NA) #1 and NA #2 providing incontinence care for Resident #85. Unit Manager (UM) #1 was present during the Resident's care. The NAs brought clean bed linens into the room and trash bags. NA #1 and NA #2 donned gloves and gowns because the Resident was on Enhanced Barrier Precautions because of a stage IV sacral wound. The NAs proceeded to turn the Resident over on her side to discover the Resident was incontinent of stool which had soiled her sacral dressing. NA #1 proceeded to remove the soft stool using multiple wipes then removed her gloves and applied clean gloves multiple times without washing or sanitizing her hands. The UM asked NA #1 to remove the soiled dressing so that another dressing could be applied. After the NA removed the dressing, she removed her gloves and applied clean gloves without using hand sanitizer or washing her hands. While waiting for the Wound Nurse to apply a new sacral dressing, NA #1 applied lotion on the Resident's back. After the new dressing was applied by the Wound Nurse the two NAs proceeded to turn the Resident over to her other side then NA #2 removed the Resident's bed linen and threw the dirty/soiled linen on the floor. The two NAs finished putting clean sheets on the bed and NA #2 picked up the soiled linen from the floor and put the linen in a trash bag. The 2 NAs removed their gowns and gloves and sanitized their hands after they left the Resident's room. An interview was conducted with NA #1 on	F 880	Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for infection control.	

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11/14/24 at 3:46 PM. The NA was asked about the incontinence care provided to Resident #85 and the NA explained that she knew she did not wash her hands after she removed her gloves even though there was a hand sanitizer dispenser on the Resident's wall in her room. She indicated she was nervous being watched during the procedure.

During an interview with NA #2 on 11/14/24 at 5:17 PM, the NA explained that she did not take care of Resident #85 often but thought she needed to get the dirty soiled linen off the bed before the Resident had another stool and NA #1 turned the Resident over on the linen. She indicated it was instinct that she threw it on the floor and knew that she should not have done that.

During an interview with Unit Manager (UM) #1 on 11/14/24 at 4:53 PM, the UM explained that she noticed NA #2 threw the dirty/soiled linen on the floor and she should not have done that because of infection control. The UM remarked the NAs had several plastic bags that they brought in with them for the dirty linen. The UM indicated she did not have time to correct NA #2 because it happened so fast. The UM also stated she did not notice that NA #1 never used hand sanitizer when she changed her gloves multiple times during the incontinence care. She reported that the facility had a skills fair about a month ago and everyone was educated on infection control.

An interview was conducted with the Director of Nursing (DON) on 11/15/24 at 9:58 AM who reported she was informed of the mistakes the two NAs made during Resident #85's incontinence care yesterday and explained that

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F 880	Continued From page 21 they both attended a skills fair about a month ago and infection control and handwashing was covered in the skills fair. The DON indicated the NAs needed to be reeducated on infection control. On 11/15/24 10:46 AM during an interview with the Administrator, she explained that the two NAs knew better and had recently been educated on infection control and would be reeducated.	F 880		