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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/12/24 through 11/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # RCFZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/12/24 through 11/15/24. Event ID# RCFZ11. The following intakes were investigated NC00210012, NC00213135, NC00213847, NC00214717, NC00217611, NC00218157, NC00218519, NC00219099, NC00219791, NC00220130, and NC00221670. 5 of the 18 complaint allegation(s) resulted in deficiency.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		12/7/24

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

Electronically Signed | 12/02/2024

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to ensure a copy of the resident's advanced directive was included in the resident's record (Resident #10) and failed to provide written advance directive information and/or an opportunity to formulate an advance directive (Residents #18, #51, and #84). This was for 4 of 17 residents reviewed for advance directives. The findings included: a. A review of the facility's policy titled "Documentation of Advanced Directives" dated 2/2007 revealed in part "It is the policy of the facility to document in the residents' medical	F 578	F578 ADVANCE DIRECTIVES On 11/28/2024, the Admission Director requested a copy of Resident #10□s advanced directive and included it in the medical record. On 11/29/2024, the Social Worker documented in the medical record that Resident #10□s POA was received. On 12/2/2024, the Social Worker documented that information regarding advance directives was offered to the Resident and/or Resident Representative (RR) for Resident #18, Resident #51, and Resident #84 regarding Living Wills, Health Care Power of Attorney (HCPOA), Medical Power of Attorney (POA), Durable	

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F 578	Continued From page 2 record whether or not the resident has executed an advanced directive. If the resident or resident's family or representative indicates that the resident has executed an advanced directive, facility staff will request that a copy of the advanced directive be provided to the facility for inclusion in the resident's record as soon as possible." Resident #10 was admitted to the facility on 10/8/24 with a diagnosis of respiratory failure. A review of Resident #10's admission Minimum Data Set (MDS) assessment dated 10/14/24 revealed she was cognitively intact. On 11/14/24 at 12:47 PM an interview with Resident #10 indicated her family member was her Power of Attorney (POA) and that family member had the written paperwork for this. She stated she did not recall anyone asking her if she had a POA when she was admitted to the facility or asking her to provide a copy of the document. On 11/14/24 at 1:00 PM a review of Resident #10's medical record did not reveal evidence of Resident #10's POA document. On 11/15/24 at 1:03 PM an interview with the Admissions Director indicated she was aware that Resident #10 had a POA document when Resident #10 was admitted to the facility. She stated she had spoken with the Social Worker at another facility, who informed her that Resident #10 had one. She went on to say she had not asked Resident #10 or her family member to provide a copy of the POA or documented this in Resident #10's medical record. On 11/15/24 at 1:57 PM an interview with the	F 578	Power of Attorney (POA) with documentation in the electronic medical record. On 11/26/2024, the Assistant Administrator initiated an audit of all residents documentation of advance directives. This audit was initiated to ensure information regarding advance directives was discussed and reviewed with the Resident and/or Resident Representative (RR) for preference for advance directives to include if resident had a living will, HCPOA, medical POA, Durable POA or desired information regarding a living will, HCPOA, medical POA, Durable POA with documentation in the electronic record. The Assistant Administrator and/or the Assistant Director of Nursing (ADON) will address all concerns identified during the audit immediately to include updating the resident electronic medical record with a copy of a living will, HCPOA, medical POA, Durable POA or provide Resident and/or the Resident Representative (RR) with information regarding Living Will, HCPOA, Medical POA, Durable POA. The audit will be completed by 12/6/2024. On 11/26/2024, the Administrator initiated an in-service with the Admission Director, Social Worker, and Medical Records Director regarding Advance Directives with emphasis on reviewing advance directives on admission to include if resident has a Living Will, HCPOA, medical POA, Durable POA or desires information regarding a Living Will,	

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F 578	Continued From page 3 Administrator indicated typically the facility's Business Office Manager requested copies of the Living Will and/or the POA, if the resident had these, during the financial interview upon admission. He stated the Business Office Manager had been out on leave. He reported he felt a copy of Resident #10's POA had not been obtained for Resident #10's medical record because the Business Office Manager normally did this. b. Review of Resident #18's medical record revealed the Resident was readmitted to the facility on 7/25/19 with diagnoses that included dementia, Parkinson's disease, and cardiovascular disease. The review revealed a full code status was care planned on 5/20/23. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. c. Review of Resident #51's medical record revealed the Resident was admitted to the facility on 11/24/21 with diagnoses that included Alzheimer's disease, dementia, and hypertension. The review revealed a full code Physician order dated 11/5/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered.	F 578	HCPOA, Medical POA, and Durable POA with documentation in the electronic record. In-service will be completed by 12/2/2024. All newly hired Admission Directors, Medical Records Directors, and Social Workers will be in-serviced during orientation by the Administrator regarding Advance Directives. The Interdisciplinary team to include the Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON), and Assistant Administrator will review all new admissions 5 times a week x 4 weeks, then monthly x 1 month, to ensure advance directives are reviewed with the Resident/Resident Representative (RR) on admission to include desired advance directive and if resident has a Living Will, HCPOA, Medical POA, and/or Durable POA or desires information regarding a Living Will, HCPOA, Medical POA, and/or Durable POA with documentation in the electronic record. The IDT team to include Director of Nursing (DON), Unit Managers, Assistant Director of Nursing (ADON), and Assistant Administrator will address all concerns identified during the audit to include reviewing advance directives with the resident/resident representative and providing information on Living Will, HCPOA, Medical POA, and/or Durable POA with documentation in the electronic medical record when indicated. The Administrator will review the audit of advanced directives weekly x 4 weeks, then monthly x 1 month, to ensure all concerns are addressed.	

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F 578	Continued From page 4 d. Review of Resident #84's medical record revealed the Resident was admitted to the facility on 3/8/21 with diagnoses that included a history of a stroke and diabetes. The review revealed a full code Physician order dated 11/5/24. There was no documentation in the record for education regarding a formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. An interview was completed on 11/13/24 at 11:15 AM with the facility's Admissions Director. She revealed that either she or the Social Worker discussed only code status with residents. A further discussion about advance directives did not take place, and there is no documentation to show the Resident's understanding beyond code status. An interview was completed on 11/13/24 at 11:50 AM with the facility's Social Worker #1. Social Worker #1 stated she only discussed code status with the Resident and/or their responsible party (RP). An interview was completed with the facility's Administrator on 11/13/24 at 2:15 PM. He revealed SW #1 documented the code status discussion in the medical record, but there was not a form for advance directives with an explanation that was signed by the Resident or the RP. The Administrator stated the only document that went into the chart was the Do Not Resuscitate (DNR) form itself and the order verification form that the physician signed.	F 578	The Administrator will forward the results of the Advance Directive Audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 1 month and review the Advance Directive Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 602	Continued From page 5	F 602		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and Medical Director interviews the facility failed to protect a resident's right to be free from the misappropriation of controlled medication for 1 of 2 residents (Resident #40) reviewed for misappropriation. Findings included: A review of the facility's policy titled "Abuse, Neglect, or Misappropriation of Resident Property" dated last revised on 3/10/2017 revealed in part "The facility believes that our residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation or misappropriation of property. The facility will do whatever is in it's control to prevent mistreatment, neglect, exploitation, and abuse of our residents or misappropriation of their property." Resident #40 was admitted to the facility on 1/31/24 with a diagnosis of chronic pain. A physician's order for Resident #40 dated 5/17/24 indicated to administer oxycodone (a narcotic pain medication) 10 milligrams	F 602	Past noncompliance: no plan of correction required.	

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(mg)/acetaminophen (a non-narcotic pain medication) 325 mg one tablet by mouth to Resident #40 four times daily for chronic pain.

A review of Resident #40's quarterly Minimum Data Set (MDS) assessment dated 6/14/24 revealed she was cognitively intact and on a scheduled pain medication regime. She received as needed medication for pain. Resident #40 had pain of an 8 on a 0 to 10 scale almost constantly with 0 being no pain and 10 being the most pain imaginable.

A review of a pharmacy packing slip dated 6/20/24 revealed the facility received 120 doses of oxycodone 10 mg/acetaminophen 325 mg tablets for Resident #40. Two nurse signatures appeared on the bottom of the packing slip acknowledging that the medication was received. The same two nurse signatures appeared at the top of the controlled substance count records for the medication which were labeled one of four, two of four, and three of four. The controlled substance count sheet four of four was missing.

A review of Resident #40's Medication Administration Record (MAR) for June 2024 revealed documentation oxycodone 10 mg/acetaminophen 325 mg one tablet was administered to Resident #40 four times a day on 6/20/24 through 6/30/24 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM as ordered by her physician.

A review of Resident #40's Medication Administration Record (MAR) for July 2024 revealed documentation oxycodone 10 mg/acetaminophen 325 mg one tablet was administered to Resident #40 four times a day on

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7/1/24 through 7/6/24 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM as ordered by her physician.

A review of the Shift Change Controlled Substances Count Check dated 7/3/24 at 7:00 AM revealed the off-going Nurse #5's and the oncoming Nurse #4's signature on the log verifying there were 23 controlled substance count sheets present. On 7/3/24 at 3:00 PM the off-going Nurse #4's and oncoming Nurse #3's signatures were present on the log verifying that there were 23 controlled substance count sheets present. On 7/3/24 at 11:00 PM the off-going Nurse #3 and the oncoming Nurse #2's signature were present on the log indicating there were 23 controlled substance count sheets present. On 7/4/24 at 7:00 AM the off-going Nurse #2's and the oncoming Nurse #4's signatures were present on the log, but the number 23 was crossed out and the number 22 was written indicating there were 22 controlled substance count sheets present with a note that the count was verified.

On 11/12/24 at 2:24 PM an interview with Resident #40 indicated she had a history of chronic pain. She stated she received medication in the facility for her pain that helped her. She stated she did not recall ever not receiving the pain medication she needed to control her pain.

On 11/15/24 at 12:39 PM an interview with Central Supply Clerk #1 indicated on 7/3/24 after 3:00 PM he needed to check the medication room to see what supplies needed to be restocked. He stated normally, the nurse would open the door to the medication room and be present while he did this, but on this occasion Nurse #3 gave him the keys, he used them to

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open up the medication room door. He went on to say he propped the door open with his cart while he restocked the supplies, and when he turned around to give Nurse #3 back her keys, she was gone. He reported he had not been in the medication room with the keys for very long, he thought maybe about 30 seconds. Central Supply Clerk #1 recalled he saw Nurse #4 and the Unit Nurse Manager at the nurses' station, and when he attempted to give the keys to the medication room to the Unit Nurse Manager, Nurse #4 reached out her hand, said "I'll take them" and took the keys from him. Central Supply Clerk #1 stated Nurse #4 told him she would give the keys to Nurse #3 when Nurse #3 got back from the bathroom. He went on to say approximately 3 to 5 minutes later he saw Nurse #3 in the hallway, asked her if she had gotten her keys back, and she told him she had.

On 11/15/24 a review of a written witness statement by Nurse #3 dated 7/8/24 revealed on 7/3/24 at the start of her 3:00 PM to 11:00 PM shift Nurse #3 completed the controlled substance reconciliation count with the off going Nurse #4. This was her first time working at the facility. Although there had been only 22 controlled medication cards in the medication cart and there were 23 listed on count sheet, when she asked Nurse #4 about it, Nurse #4 had given her an explanation for it, and so she signed the count sheet for 23 controlled medications and sheets. Nurse #3 remembered giving Central Supply Clerk #1 the keys to the medication room and leaving the medication cart at the nurse's station while she went to the bathroom. When Nurse #3 returned from the bathroom, Nurse #4 gave these keys back to her.

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On 11/15/24 at 10:19 AM, 12:42 PM and 3:07 PM attempts to reach Nurse #3 for a telephone interview were unsuccessful. Nurse #3 no longer worked at the facility, and no other method of contact for her was available.

On 11/15/24 at 10:18 AM a telephone interview with Nurse #4 indicated she was assigned to care for Resident #40 on 7/3/24 from 7:00 AM until 3:00 PM. Nurse #4 explained Nurse #3 was new to the and she had taken Nurse #3 around the facility, given her report on the residents, and done the controlled medication reconciliation with Nurse #3 before giving Nurse #3 the keys to the controlled substances and the medication cart at about 3:30 PM on 7/3/24. Nurse #4 reported she recalled there being 23 controlled medications and 23 controlled substance count record sheets present. She stated she stayed for a while after her shift ended that day and was at the nurses' station at about 3:45 PM on 7/3/24 when Central Supply Clerk #1 came up to the nurses' station where she was seated looking for Nurse #3. Nurse #4 reported Central Supply Clerk #1 had the keys to the medication cart which included the keys to the controlled substances and wanted to return them to Nurse #3. She went on to say she had not seen Nurse #3 give the keys to the medication cart to Central Supply Clerk #1. She reported the medication cart had been in the hallway next to the nurses' station where she was seated. Nurse #4 indicated she had not seen Central Supply Clerk #1 access the medication cart or use the keys to access the locked medication room which was about 3 doors down from the nurse's station, although she could see both the cart and the room from where she was seated. Nurse #4 stated she told Central Supply Clerk #1 that Nurse #3 was in the bathroom, and

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that he could lay the keys on the counter at the nurses' station, which he did. Nurse #4 reported that she could see the keys to the medication cart lying on the counter at the nurse station the entire time until Nurse #3 came out of the bathroom and picked them up a few minutes later. The interview further revealed when she returned to the facility on 7/4/24 for her 7:00 AM to 3:00 PM shift and was reconciling the controlled medication in the medication cart with Nurse #2, she noticed Resident #40 was missing a card of 30 doses of oxycodone 10 mg/acetaminophen 325 mg and the controlled substance count record sheet that went with the medication. She reported the shift change controlled substance count check sheet indicated there should be 23 count sheets and 23 narcotic medications in the cart, but there had only been 22. She went on to say Nurse #2 asked her how she knew Resident #40 was missing a card of 30 doses of oxycodone 10 mg/acetaminophen 325 mg and the controlled substance count record sheet for this medication before they had finished reconciling the controlled medication, and she told her she knew what was supposed to be in the cart because she was very familiar with that medication cart and was the regular nurse for that hall. Nurse #4 indicated she did not know what happened to the medication or the sheet and she and Nurse #2 had immediately reported the discrepancy to the Unit Nurse Manager.

On 11/15/24 at 9:25 AM a telephone interview with Nurse #2 indicated she was assigned to care for Resident #40 on 7/3/24 from 11:00 PM until 7/4/24 at 7:00 AM. She stated when she counted the controlled narcotic medication on 7/4/24 at 11:00 PM with the off going Nurse #3 who was assigned to care for Resident #40 on 7/3/24 from

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3:00 PM until 11:00 PM she noticed the number of controlled medications and the number of the controlled substance count record sheets did not match what was on the shift-change controlled substance count check log. She stated the shift change controlled substance count check log indicated there should be 23 controlled medication cards and 23 controlled substance count records but there had only been 22. Nurse #2 reported she had asked Nurse #3 why this was, and Nurse #3 informed her Nurse #4, who had been assigned to care for Resident #40 on 7/3/24 from 7:00 AM until 3:00 PM, had instructed her that the 2 cards of a narcotic medication in a bag were supposed to be counted as 2. Nurse #2 stated she had been working at the facility for the past 3 years, and she didn't think this was correct, but if she counted the medication in the bag as 2 then there would have been 23 controlled medications. She went on to say the pharmacy had come to deliver medications while she was performing the controlled substance reconciliation with the off going Nurse #3 on 7/3/24, and she had accepted the keys to the medication cart without completing the controlled substance reconciliation and signed the shift change controlled substance count check log to indicate there were 23 medication cards present. Nurse #2 reported she thought she would figure out why the narcotic count seemed to be incorrect later on in her shift, but she had gotten busy and had not. She went on to say the next morning, on 7/4/24 at 7:00 AM when she and the oncoming Nurse #4 began to perform the narcotic reconciliation, she asked Nurse #4 whether or not she instructed Nurse #2 to count the narcotic medication in the bag as 2 and Nurse #4 told her she had not said this. Nurse #2 stated before she and Nurse #4 finished the controlled medications reconciliation,

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Nurse #4 told her Resident #40 was missing a whole card of 30 doses of oxycodone 10 mg/acetaminophen 325 mg. Nurse #2 went on to say she thought this was strange, because she and Nurse #4 had not even finished reconciling the controlled medications when Nurse #4 said this. Nurse #2 reported she had asked Nurse #4 how she knew what was missing, and Nurse #4 told her she knew how much of this medication Resident #40 was supposed to have because she was Resident #40's regularly assigned nurse. Nurse #2 indicated she did not know what happened to the missing medication or the record sheet. She stated the discrepancy had been reported to the Unit Nurse Manager on 7/4/24.

On 11/15/24 at 8:35 AM an interview with the Unit Nurse Manager indicated on 7/3/24 after 3:00 PM she was in the hallway and heard Central Supply Clerk #1 ask Nurse #4 for assistance with getting into the medication room. The Unit Manager stated she heard Nurse #4 ask Central Supply Clerk #1 to wait a moment and she would help him. She reported a few minutes later that Central Supply Clerk #1 attempted to give her some keys, but Nurse #4 offered to take the keys from him. She reported she saw Central Supply Clerk #1 give the keys to Nurse #4. The Unit Nurse Manager did not discuss why she allowed Central Supply Clerk #1 to give the keys to Nurse #4, or why she had not questioned the situation on 7/3/24. She went on to say on 7/4/24, Nurse #2 and Nurse #4 reported to her that there was a card of 30 doses of Resident #40's oxycodone 10 mg/acetaminophen 325 mg and the controlled substance count record sheet that went with the medication missing from the medication cart. She reported she verified the medication, and the record sheet were missing, and immediately

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reported the medication discrepancy to the Director of Nursing. The Unit Nurse Manager stated Nurse #4 should not have had the keys to the medication cart and the controlled substances after she passed the keys to Nurse #3 at the end of her shift on 7/3/24, and Central Supply Clerk #1 should never have been allowed to have these keys or access to the areas where medications were kept unsupervised.

On 11/15/24 at 11:47 AM a telephone interview with the Pharmacy Manager indicated on 6/20/24 the pharmacy dispensed 120 doses of oxycodone 10 mg/acetaminophen 325 mg to the facility for Resident #40. He stated Resident #40 took one dose of this medication 4 times daily. He went on to say the 120 doses should have been a 30 day supply of the medication for Resident #40. The Pharmacy Manager reported on 7/10/24, the pharmacy had to reissue a 10 day supply of the medication early, billed to the facility and not to Resident #40, because of diversion of the medication by someone at the facility.

On 11/15/24 at 1:18 PM an interview with the Director of Nursing (DON) indicated a full card of 30 doses of Resident #40's oxycodone 10 mg/acetaminophen 325 mg medication and the controlled substance count record sheet for the medication had gone missing by the Unit Nurse Manager on 7/4/24 between 7:00 AM and 8:00 AM. She stated she had been involved in the investigation. The DON reported there should always be clarification immediately prior to accepting the keys to the medication cart as soon as there was any question about the accuracy of the controlled substance reconciliation. She stated she had not been made aware of any concern with the controlled substance

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reconciliation count until 7/4/24. The DON stated the nurse should never pass the keys to their medication cart to anyone after they had counted the narcotic medications and accepted responsibility for the medication cart. She reported Nurse #4 should not have had access to the medication cart keys after she performed the controlled substance reconciliation with Nurse #3 at the end of her shift on 7/3/24. The DON stated although these were things that she felt should just be basic nursing knowledge, since this incident the facility had done in-service education with all nurses and medication aides, and it was included in the facility's orientation process. She went on to say a corrective action plan for the incident had been implemented. She reported the follow-up audits had not revealed any additional concerns. The DON stated she continued to periodically monitor and reconcile the controlled substances in the medication carts.

On 11/15/24 at 1:57 PM an interview with the Administrator indicated the facility had confirmed that Resident #40's 30 doses of oxycodone 10 mg/acetaminophen 325 mg medication and the controlled substance count record sheet for the medication had gone missing on 7/4/24. He stated an investigation had been competed, replacement medication had been ordered from the pharmacy and billed to the facility, and Resident #40 had not missed any doses of the medication. He reported Nurse #4 had been hired at the facility in August 2023, and the facility had been aware that she had a reprimand on her nursing license from the North Carolina Board of Nursing (NCBON) related to concerns about missing narcotic medications and the documentation of controlled substances by Nurse #4 when she was hired. He stated Nurse #4 had

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not had any restrictions on her nursing license and had been allowed to handle and administer controlled substance medications. He went on to say although he could not prove it, he believed Nurse #4 was responsible for Resident #40's missing medication. The Administrator stated Nurse #4 no longer worked at the facility, and he had reported the incident to the NCBON. He reported an initial and 5 day investigation report had been submitted to the State Agency, Adult Protective Services and the Medical Director had been notified of the incident, and a report to law enforcement had been made. He went on to say the missing controlled medication had been reported to the Drug Enforcement Agency. The Administrator stated the facility completed an investigation of the incident and implemented a performance improvement plan. He went on to say there had been no additional concerns on their follow-up audits. He stated this incident, and the follow-up audits had been discussed in the Quality Assurance and Performance Improvement meetings.

On 11/15/24 at 11:49 AM an interview with the Medical Director indicated she had not been the Medical Director for the facility when the incident occurred. She went on to say the previous Medical Director no longer worked for the company, and no contact for him was available. She stated the positive thing was that Resident #40 had not missed any doses of her oxycodone 10 mg/acetaminophen 325 mg medication and had not suffered any negative outcome.

The facility provided the following corrective action plan:

Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice;

- On 7/4/2024, the Administrator and Director of Nursing (DON) were notified of missing medication from the medication cart for a resident. The Administrator and Director of Nursing initiated an investigation regarding missing medications.

- The resident was assessed by nursing staff for signs and symptoms of pain on 7/4/2024. No significant findings noted from the assessment. The resident was able to receive pain medication from remaining doses on the medication cart. The resident and the Resident Representative (RR) were made aware of the missing medication. The medication was reordered from the pharmacy.

- Initial allegation report was submitted to Division of Health Service Regulation (DHSR) on 7/4/2024 by the Administrator.

- The local law enforcement agency was made aware of the missing medication on 7/4/2024 by the Administrator. A report was completed for the missing medication.

- The facility Medical Director and the resident's RR were made aware of the missing medication on 7/4/2024 by the Administrator and Director of Nursing. The Medical Director had no new orders.

- The Drug Enforcement Agency was notified of the missing medication on 7/5/2024 by the Administrator.

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F 602	Continued From page 17 - NCBON was notified of the missing medication on 7/8/2024 by the Director of Nursing. - APS made aware of the investigation on 7/4/2024 by the Administrator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; - On 7/4/2024 the Unit Managers completed an audit of the last 30 days of ordered narcotic medications to ensure the medications were in the medication cart, administered, or returned to pharmacy per protocol. No concerns were noted during the audit. - On 7/4/2024, the Director of Nursing reviewed packing slips for the past 30 days to ensure all narcotic medications were checked in appropriately and accounted for. No concerns were noted from the audit. - On 7/4/2024, the Director of Nursing completed an audit of 100% of all resident's Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart to ensure there were no discrepancies in the count of the medications. No concerns were noted from this audit. - On 7/4/2024, the Unit Managers inspected the narcotic blister pill packages for any tampering of medications. No concerns with tampering were noted. - On 7/4/2024, the Unit Managers and Assistant Director of Nursing initiated assessment of all	F 602		

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residents for pain. The Director of Nursing will address will initiate non-pharmacological interventions, pain medication, and/or physician notification for any identified areas of concern during the audit. The audit was completed by 7/5/2024. No concerns were noted from this audit.

- On 7/5/2024, the Accounts Payable completed an audit of all nurses and medication aides' license verification and HCPI checks. No concerns were noted from this audit.

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

- On 7/4/2024, the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding Controlled Substance Diversion to include: the definition, implications, the process for returning narcotic medications, and not removing the declining count sheet from the controlled substance book until the end of the shift to ensure it is signed by 2 nurses. The in-service also will discuss reporting discrepancies immediately to the nurse manager, not accepting a medication cart until the discrepancy is investigated and not allowing any other nurse to have access to the medication cart if it is not their assigned medication cart. The in-service was completed by 7/5/2024. After 7/5/2024, any nurse or medication aide that had not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses or medication aides will be educated during orientation by the Staff Development Coordinator regarding Controlled Substance Diversion. On 7/5/24, the

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Administrator notified the Director of Nursing her responsibility to monitor and to ensure all in-services are completed per the plan of correction.

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

- 100 % of all ordered narcotic medications will be reviewed by the Assistant Director of Nursing weekly x 4 weeks and compared to the Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the narcotic medications are being administered or have been returned to pharmacy as required per policy and there are no signs of drug diversion utilizing a Controlled Substance Audit tool. All areas of concern will be addressed during the audit including re-educating nurses. The DON will review and initial the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.

- The Administrator or DON will present the findings of the Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the audit tools to determine trends and/or issues that may need further interventions and the need for additional monitoring.
Include dates when corrective action will be completed.

- Corrective action was completed on 7/6/2024.

Onsite validation of the facility's Plan of Correction was completed on 11/15/24. The initial

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F 602	Continued From page 20 audit results were reviewed. The in-service education record dated 7/5/24 was reviewed. Interviews with nurses and medication aides indicated they attended and/or received in-service training on misappropriation of controlled substances and handling of the medication cart and controlled substance medications. The follow-up audit results were reviewed. The QAPI meeting minutes were reviewed. The facility's completion date of 7/6/24 was validated.	F 602		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		12/7/24

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F 657	Continued From page 21 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident, Resident Representative (RR) and staff interviews, the facility failed to conduct care plan meetings or invite residents to their care plan meetings for 4 of 9 residents reviewed for care plans (Residents #39, #40, #100, and 117). Findings included: 1. Resident #39 was admitted to the facility on 12/5/2017 with diagnoses which included Alzheimer's disease and aphasia (unable to speak). The quarterly Minimum Data Set assessment dated 10/28/24 indicated that Resident #39 was severely cognitively impaired. An interview on 11/12/24 at 11:13 AM with Resident #39's Resident Representative (RR) revealed she had not been invited to a care plan meeting since Resident #39's admission. She stated she would like to attend a care plan meeting. An interview on 11/13/24 at 1:21 PM with the Social Worker (SW) #1 revealed that based on Resident #39's record, it appeared she had not had a care plan meeting since 4/5/2018. The SW indicated he was aware of the requirement to hold care plan meetings quarterly. An interview on 12/13/24 at 2:55 PM with the	F 657	F 657 Care Plan Timing and Revision On 11/26/2024, the Social Worker scheduled a care plan meeting for 11/27/2024 for Resident #39 and invited Resident #39 and the Resident Representative (RR) to attend. Notification of Resident #39 and RR of scheduled care plan meeting with invitation to attend was documented in the electronic medical record. On 11/19/2024, the Social Worker scheduled a care plan meeting for 11/21/2024 for Resident #40 and invited Resident #40 to attend. Resident #40 is own Resident Representative (RR). Notification of scheduled care plan meeting with invitation to attend was documented in the electronic medical record. On 11/26/2024, the Social Worker scheduled a care plan meeting for 11/27/2024 for Resident #100 and invited Resident #100 and the Resident Representative (RR) to attend. Notification of Resident #100 and RR of scheduled care plan meeting with invitation to attend was documented in the electronic medical record. On 11/27/2024, the Social Worker	

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F 657	Continued From page 22 Administrator revealed he was unaware that Resident #39 had not had a care plan meeting since 2018. He stated SW #1 made the care plan meeting schedule and sent the invitations by mail to residents' RRs, or hand delivered them to residents who were their own responsible party. 2. Resident #100 was admitted to the facility on 5/3/23. A review of Resident #100's care plan revealed it was last updated on 10/6/24. A review of Resident #100's quarterly Minimum Data Set (MDS) assessment dated 10/25/24 revealed he was moderately cognitively impaired. On 11/12/24 at 1:35 PM an interview with Resident #100 indicated he did not recall ever being invited to attend a care plan meeting. He stated he would like to be invited to attend. On 11/13/24 a review of Resident #100's medical record did not reveal any documentation that a care plan meeting was conducted since Resident #100's admission to the facility. On 11/13/24 at 11:03 AM an interview with MDS Nurse #1 indicated Resident #100's Social Worker (SW) was responsible for sending the invitations and for arranging Resident #100's care plan meetings. She reported a care plan schedule calendar was generated based on the MDS assessment dates and provided to the SW. She further indicated Resident #100 would have been scheduled for a care plan meeting in accordance with his 10/25/24 MDS assessment. On 11/13/24 at 12:42 PM an interview with SW #2	F 657	scheduled a care plan meeting for 11/27/2024 for Resident #117 and invited Resident #117 and the Resident Representative (RR) to attend. Notification of Resident #117 and RR of scheduled care plan meeting with invitation to attend was documented in the electronic medical record. On 11/26/2024, the Assistant Administrator initiated an audit of all residents' most recent care plan meetings. This audit was initiated to ensure that a care plan meeting was scheduled and completed per facility guidelines and that the Resident and/or Resident Representative (RR) were provided a written invitation to the care plan meeting with documentation in the electronic record. The Assistant Director of Nursing (ADON) and/or Assistant Administrator will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting for any Resident or Resident Representative (RR) who was not provided with a written invitation per facility protocol and provide written documentation of attending/declining to attend care plan meeting. The audit will be completed by 12/6/2024. On 11/26/2024, the Administrator initiated an in-service with the Social Workers and the Minimum Data Set (MDS) nurses regarding Resident Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) timely scheduling of care plan meetings	

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F 657	Continued From page 23 indicated Resident #100 was due for a care plan meeting around the time of the 10/25/24 MDS assessment. He stated he was responsible for providing the invitation to the meeting, and for maintaining the documentation of the meeting including those who attended. SW #2 stated care plan meetings included the resident and their Representative if this applied, a Nurse, a Nurse Aide, Activities, Dietary, and Therapy if this applied. He reported he had been Resident #100's SW since Resident #100's admission to the facility. SW #2 stated he had not invited Resident #100 to a care plan meeting and had no documentation that a meeting occurred. He went on to say care plan meetings were important and should be held at least quarterly and as needed. SW #2 stated he did not have a reason why a care plan meeting for Resident #100 had not been held. On 11/13/24 at 1:42 PM an interview with the Director of Nursing (DON) indicated care plan meetings should be held at specific intervals for residents. She stated she did not have any documentation that a care plan meeting had been held for Resident #100 since his admission to the facility. On 11/15/24 at 11:57 AM an interview with the Administrator indicated care plan meetings were required for residents. He stated the resident needed to be invited to the meetings, and all disciplines needed to be represented at the meeting. The Administrator stated care plan meetings should be held on admission, quarterly, and any time there was a significant change with the resident. 3. Resident #40 was admitted to the facility on	F 657	following admission, with changes in plan of care and/or quarterly and (3) providing the Resident and/or Resident Representative (RR) a written invitation to care plan meeting with documentation in the electronic record. The in-service will be completed by 12/2/2024. All newly hired Social Workers and/or Minimum Data Set (MDS) nurses will receive the in-service during orientation by the Administrator. The Assistant Director of Nursing (ADON) and/or the Assistant Administrator will audit 10% of newly held care plan meetings to include Resident #39, Resident #40, Resident #100, and Resident #117, and newly admitted/re-admitted residents and/or scheduled quarterly reviews weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Meeting Audit tool to ensure a care plan meeting was scheduled and completed per facility guidelines and that the Resident and/or Resident Representative (RR) was provided a written invitation to the care plan meeting with documentation in the electronic record. The Assistant Director of Nursing (ADON), Assistant Administrator, and/or Administrator will address all concerns identified during the audit to include, but not limited to, scheduling a care plan meeting per facility guidelines, providing a written invitation to the Resident and/or Resident Representative (RR) with documentation in the electronic record and/or re-education of staff. The Administrator will review the Care Plan	

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F 657	Continued From page 24 1/31/24. A review of Resident #40's quarterly MDS assessment dated 10/18/24 revealed she was cognitively intact. A review of Resident #40's care plan revealed it was last revised on 10/22/24. On 11/12/24 at 2:24 PM an interview with Resident #40 indicated she did not recall being invited to a care plan meeting. She stated she would like to be invited to attend. On 11/12/24 a review of Resident #40's medical record did not reveal any documentation that a care plan meeting was conducted for Resident #40 since her admission to the facility. On 11/13/24 at 11:03 AM an interview with MDS Nurse #1 indicated Resident #40's SW was responsible for sending the invitations and arranging Resident #40's care plan meetings. She reported a care plan schedule calendar was generated based on the MDS assessment dates and provided to the SW. She further indicated Resident #40 would have been scheduled for a care plan meeting in accordance with her 10/18/24 MDS assessment. On 11/13/24 at 12:42 PM an interview with SW #2 indicated Resident #40 was due for a care plan meeting around the time of the 10/18/24 MDS assessment. He stated he had been Resident #40's SW since her admission to the facility. SW #2 reported he was responsible for providing the invitation to the meeting, and for maintaining the documentation of the meeting including those who attended. SW #2 stated care plan meetings	F 657	Meeting Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the results of the Care Plan Meeting Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 657	Continued From page 25	F 657		

included the resident and their Representative if this applied, a Nurse, a Nurse Aide, Activities, Dietary, and Therapy if this applied. He reported he had not invited Resident #40 to a care plan meeting and had no documentation that a meeting occurred since Resident #40's admission to the facility. He went on to say care plan meetings were important and should be held at least quarterly and as needed. SW #2 stated he did not have a reason why a care plan meeting for Resident #40 had not been held.

On 11/13/24 at 1:42 PM an interview with the Director of Nursing (DON) indicated care plan meetings should be held at specific intervals for residents. She stated she did not have any documentation that a care plan meeting had been held for Resident #40 since her admission to the facility.

On 11/15/24 at 11:57 AM an interview with the Administrator indicated care plan meetings were required for residents. He stated the resident needed to be invited to the meetings, and all disciplines needed to be represented at the meeting. The Administrator stated care plan meetings should be held on admission, quarterly, and any time there was a significant change with the resident.

4. Resident #117 was admitted to the facility on 9/11/24, and her diagnoses included acute cerebrovascular insufficiency, vascular dementia, hypertension, and diabetes.

The quarterly Minimum Data Set (MDS) assessment dated 10/13/24 revealed Resident #117 was moderately cognitively impaired.

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Review of Resident #117's care plan revealed it had been reviewed and revised on 9/12/24 and 10/23/24 by the interdisciplinary team.

Review of the care plan meeting signature sheet dated 9/12/24 showed those in attendance were the Social Worker, Activity Director and Resident #117's Representative (via telephone). Resident #117 had not attended the care plan meeting.

Review of the care plan meeting signature sheet dated 10/23/24 showed those in attendance were the Social Worker, Activity Director, and a registered nurse who worked on the hall. Resident #117's Representative attended via telephone. Resident #117 had not attended the care plan meeting.

Attempts were made to reach Resident #117's Representative to obtain an interview via telephone with no return call.

The Social Worker was interviewed on 11/12/24 11:00 AM, and stated if the resident was alert and oriented, she verbally notified the resident of a care plan meeting. She had not invited Resident #117 to care plan meetings because she did not consider the resident to be alert and oriented.

An interview with Resident #117 was held on 11/13/24 at 2:45 PM, during which she stated she would like to be invited and involved in the planning of her care.

The Assistant Administrator was interviewed on 11/14/24 at 9:12 AM. She revealed that the Social Worker initiated the care plan meeting. If a resident was not alert and oriented the resident representative was invited to attend the meeting.

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F 657	Continued From page 27 The Assistant Administrator explained that the Social Worker referenced the Brief Interview for Mental Status (BIMS) in the MDS assessment to determine if a resident was alert and oriented. The Social Worker verbally notified residents of the upcoming care plan meetings. If the BIMS of a resident was 12 or higher the Social Worker invited them to participate in the planning of care. An interview with the Administrator on 11/15/24 at 1:27 PM revealed his expectation was that the resident was invited to care plan meetings and that written invitations were given to both the resident and resident representative.	F 657		
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, record review, resident and staff interviews the facility failed to provide nail care for a dependent resident for 1 of 7 residents reviewed for activities of daily living (ADL) (Resident #18). The findings included: Resident #18 was readmitted to the facility on 7/25/19 with diagnoses that included dementia, Parkinson's disease, and early onset cerebellar ataxia (lack of voluntary coordination of muscle movement beginning at the cerebellum of the brain).	F 677	F677 ADL Care Provided for Dependent Residents On 11/13/2024, Resident #18's fingernails were trimmed by the assigned Nursing Assistant. The Unit Manager completed an audit including an observation of Resident #18's nails, and validated Resident #18's fingernails had been trimmed. On 11/25/2024, an audit of all residents' nails including fingernails and toenails were initiated by the Unit Managers using the Nail Care Audit Tool. The audit will be	12/7/24

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F 677	Continued From page 28 A review of a care plan dated 5/5/22 revealed Resident #18 had activities of daily living and personal care deficit with interventions which included Resident #18 was totally dependent on staff for bathing and preferred bed baths. A review of a quarterly Minimum Data Set (MDS) dated 9/26/24 revealed Resident #18 was moderately cognitively impaired and was not coded for rejection of care. Resident #18 required total dependence with bathing and grooming An observation and interview with Resident #18 were conducted on 11/12/24 at 11:54 AM. Resident #18 was observed to have approximately half-inch long fingernails with jagged nails on both thumbs. Resident #18 could only respond with head movements to questions, and he nodded affirmatively that he wanted them trimmed. A review of the Electronic Health Record shower documentation from 11/10/24 until 11/12/24 revealed Resident #18 received bed baths on each day from Nurse Aide (NA) #1. An interview was conducted on 11/13/24 at 2:39 PM with NA #1. NA #1 stated Resident #18 was totally dependent on staff during bathing. She indicated she had given him a bath in the morning of 11/13/24 and cleaned his nails. NA #1 stated that Resident #18's nails were not at a length where they needed to be trimmed. An observation and follow-up interview with NA #1 were conducted on 11/13/24 at 2:48 PM. Resident #18 was observed to have half inch-long fingernails with thumbnails jagged at	F 677	completed by 12/2/2024. All areas of concern will be addressed immediately by the Unit Managers and/or the Assistant Director of Nursing (ADON) to include completion of podiatry referrals, providing nail care, and/or providing retraining as indicated. On 11/25/2024, an in-service was initiated by the Staff Development Coordinator (SDC) with all nurses and nursing assistants regarding proper nail care. The in-service will be completed by 12/6/2024. After 12/6/2024, any nurse and/or nursing assistant that has not worked will receive the in-service by the Staff Development Coordinator (SDC) upon the next scheduled shift. All newly hired nurses and/or nursing assistants will receive the in-service during orientation by the Staff Development Coordinator (SDC). The Assistant Director of Nursing (ADON) and/or the Unit Manager will audit all residents' fingernails and toenails, including Resident #18, utilizing the Nail Care Audit Tool weekly x 4 weeks, then monthly x 1 month. Any identified areas of concern will be addressed during the audit by the Unit Manager and/or the Assistant Director of Nursing (ADON) including completing podiatry referrals, providing nail care, and/or providing retraining as indicated. The Director of Nursing (DON) will review and initial the audits weekly x 4 weeks, then monthly x 1 month, to ensure all areas of concern were addressed appropriately.	

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F 677	Continued From page 29 either side. She stated she would cut his nails today. An observation and interview were conducted with Nurse #1 on 11/13/24 at 2:52 PM. Nurse #1 stated Resident #18's nails should have been cut due to a few jagged edges on the thumbnails. The Director of Nursing (DON) was interviewed on 11/14/24 at 12:36 PM. She stated she expected nails to be checked every time care was provided. The DON indicated nails should be cut/trimmed as needed, especially if they were jagged. She stated that Resident #18's nails should have been cut previously when observed to be jagged. During an interview with the Administrator on 11/14/24 at 2:46 PM, he revealed that if Resident #18's nails needed to be cut, then they should have been cut in a timely manner.	F 677	The Administrator and/or Director of Nursing (DON) will present the findings of the Nail Care Audit Tools to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months. The QAPI Committee will meet monthly x 2 months and review the Nail Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
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 temperature controls, and permit only authorized	F 761		12/6/24

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F 761	Continued From page 30 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 and staff interviews the facility failed to discard expired medication that remained on the medication cart available for use. This was for 1 of 4 medication carts (Upper 300 Hall) reviewed for medication storage. Findings included: On 11/14/24 at 4:11 PM an observation of the Upper 300 Hall medication cart and interview with the Unit Manager occurred. The observation of the medication cart revealed an opened 355 milliliter (ml) bottle of Antacid Liquid medication with an expiration date of July 2024. The bottle contained liquid medication. An interview with the Unit Manager at that time indicated there was liquid medication remaining in the bottle. She reported this Antacid Liquid medication was expired and should not have been on the medication cart available for use. She stated she checked this medication cart weekly for expired medications and had last checked it on 11/11/24 or 11/12/24. She went on to say she must have missed this bottle. On 11/15/24 at 1:18 PM an interview with the	F 761	F761 Label/Store Drugs and Biologicals On 11/14/2024, the Unit Manager removed and discarded the opened 355 ml bottle of Antacid Liquid Medication with an expiration date of July 2024 from the Upper 300 hall medication cart. On 11/25/2024, the Unit Managers initiated an audit of all medication carts and medication storage rooms to include the Upper 300 hall medication cart. The audit is to ensure medication is labeled with an open date or use by date when opened if indicated and no medications are noted to be expired. All identified areas of concern will be addressed by the Unit Managers during the audit to include discarding expired medications and/or providing additional training. The audit will be completed by 12/2/2024. On 11/25/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses and medication aides	

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F 761	Continued From page 31 Director of Nursing (DON) indicated the medication carts were monitored weekly by the Unit Manager for expired medications and these were discarded. She stated there should not be any expired medications on any medication carts available for use. On 11/15/24 at 1:57 PM an interview with the Administrator indicated there should not be expired medication on a medication cart available for use.	F 761	regarding to Medication Storage with emphasis on (1) checking medications before administration for expired dates (2) appropriately discarding expired medications per pharmacy policy, and (3) labeling medications with an open date or use by date when indicated. In-service will be completed by 12/2/2024. After 12/2/2024, any nurse or medication aide who has not worked or received the in-service will complete it upon next scheduled work shift. All newly hired nurses and medication aides will be in-serviced during orientation by the Staff Development Coordinator (SDC) regarding Medication Storage. The Unit Managers will audit all medication carts and medication storage rooms to include the Upper 300 hall medication cart weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. The audit is to ensure medication is labeled with an open date or use by date when opened if indicated and no medications were noted to be expired. All identified areas of concern were addressed by the Unit Managers during the audit to include dating items when indicated, removal of expired medication and re-training of staff. The Director of Nursing (DON) will review the Medication Audit Tool weekly x 4 weeks then monthly x 1 month. The Director of Nursing (DON) will forward the results of Medication Audit Tool to the Quality Performance Improvement (QAPI) Committee monthly	

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F 761	Continued From page 32	F 761	x 2 months. The QAPI Committee will meet monthly x 2 months and review the Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	