STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(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 survey was conducted on 11/18/24 through 11/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1A9311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/24 through 11/21/24. Event ID# 1A9311. The following intakes were investigated: NC00214658, NC00216787, NC00222899, and NC00223787. 16 of the 16 complaint allegations did not result in deficiency. The Statement of Deficiencies was amended on 12/06/24 at tag F578.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.	F 559		12/16/24

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

Electronically Signed | 12/13/2024

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F 559	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide written notification of a roommate change for 1 of 1 resident reviewed for notification of a change (Resident #37). The findings included: Resident # 37 was admitted to the facility on 5/31/23. The quarterly Minimum Data Set (MDS) assessment dated 9/4/24 revealed Resident #37 was cognitively intact. An interview was completed on 11/18/24 at 10:00 a.m. with Resident #37. Resident #37 stated approximately 2 to 3 weeks ago she received a new roommate. Resident #37 stated prior to that day she was in a room alone. The Resident stated she went out to an appointment and when she returned, she had a new roommate. Resident #37 stated she had not received written or verbal notification she would be getting a new roommate. Review of facility records revealed Resident #37 received a new roommate on 10/29/24. There was no documentation in the medical record for Resident #37 indicating a discussion or notification of a new roommate in October 2024. An interview was completed on 11/20/24 at 2:10 p.m. with the facility's Social Worker (SW). The SW stated it was her process to contact residents and their responsible party prior to the resident	F 559	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F559 The facility failed to provide written notification of roommate change for 1 resident reviewed 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/6/24, a new user defined assessment was added to Point Click Care Room or Roommate Change User Defined Assessment. This assessment will be completed and printed to provide written notification. On 12/12/2024 the Social Service Director completed the UDA and provided written notification of the room change to resident #37. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/9/24, the Director of Nursing audited the last month of room changes to ensure written notification was provided. Two residents had changed rooms and both had been provided written notice and notified of roommate change. Room or Roommate User Defined	

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F 559	Continued From page 2 receiving a new roommate. The SW revealed she only notified a resident and their Responsible Party (RP) verbally and not in writing when there was a change in roommates. The SW stated she did not notify Resident #37 or their RP verbally or in writing that Resident #37 would be getting a roommate. The SW was unable to say why she did not provide notification. An interview was completed on 11/21/24 at 11:30 a.m. with the Director of Nursing and the facility Administrator. The Administrator stated it was his expectation a resident and their RP would be notified of a roommate change verbally and in writing prior to the roommate change.	F 559	Assessment and provided written documentation to the resident. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/6/24, the Nurse Consultant provided education to the Director of Nurses, Admission Coordinator and the Social Service Director that written notification is to be provided to residents and/or Responsible Party prior regarding a room change or roommate change, included in this education a new user defined assessment was added to Point Click Care Room or Roommate Change UDA. This assessment will be completed and printed to provide written notification. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Director of Nursing and/or designee will audit all room and roommate changes for notification of the Resident and/or Responsible Party for compliance. This monitoring will be completed weekly x 2 weeks and then monthly times 3 months or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit	

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F 559	Continued From page 3	F 559	Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	
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 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	F 578		12/16/24

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F 578	Continued From page 4 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, resident, and staff interviews, the facility failed to provide written documentation for advance directive information and the opportunity to formulate an advance directive for 13 of 22 residents reviewed for advanced directives. Residents #57, #71, #58, #55, #70, #68, #29, #72, #38, #52, #65, #61, #45. The findings included: a. Resident #57 was admitted to the facility on 7/22/24. Resident #57 had severe cognitive impairment. Review of a physician ' s order dated 7/24/24 revealed Resident #57 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. b. Resident #71 was admitted to the facility on 6/19/24. Resident #57 was cognitively intact. Resident #71 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623***F578 The facility failed to provide written documentation for advance directive information and the opportunity to formulate ab advance directive for 13 of 22 residents reviewed. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/6/24, the Social Service Director provided written documentation for advance directives and provided review for advance directive with documentation in medical record for resident #57, #71, #58, #55, #70, #68, #29, #72, #38, #52, #65, #61, and #45. This was completed	

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F 578	Continued From page 5 offered to the resident or their responsible party. c. Review of Resident #58 was admitted to the facility on 12/18/23. Resident #58 was cognitively intact. Review of a physician ' s order dated 9/25/24 revealed Resident #58 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. d. Resident #55 was admitted to the facility on 9/8/21.Resident #55 had moderate cognitive impairment. Resident #55 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. e. Resident #70 was admitted to the facility on 10/16/23. Resident #70 was cognitively intact. Review of a physician ' s order dated 10/23/23 revealed Resident #70 was a full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. f. Resident #68 ' s was admitted to the facility on 6/27/23. Resident #68 was cognitively intact. Resident #68 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was	F 578	on 12/ 09 /20 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/09/24, the Director of Nursing began auditing all current residents for documentation of advance directive review and documentation in medical record of this review. This audit was completed on 12/12/2024. On 12/6/24, The Social Worker or designee began completing resident and resident representative interviews to determine wishes for Advanced Directives and completing documentation in medical record of decision of Advance Directive. This was completed on 12/13/24. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/6/24, the Nurse Consultant provided education to the Social Service Director, Admissions Coordinator, and Director of nursing on written documentation to be provided to resident and/or RP on advance directives and documentation to be in medical record of review and who review was conducted with. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Director of Nursing or designee will audit 5 residents for compliance. This monitoring will be completed weekly x 4 weeks and then monthly times 3 months or until resolved. Reports will be presented to the monthly Quality	

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F 578	Continued From page 6 offered to the resident or their responsible party. g. Resident #29 was admitted to the facility on 11/25/19. Resident #29 had severe cognitive impairment. Resident #29 held a physician order for Do Not Resuscitate (DNR). There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. h. Resident #72 was admitted to the facility on 6/21/24. Resident #72 was cognitively intact. Resident #72 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. i. Resident #38 was admitted to the facility on 10/31/23. Resident #38 was cognitively intact. Resident #38 held a physician order for Do Not Resuscitate (DNR). There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party. j. Resident #52 was admitted to the facility on 8/8/23. Resident #52 was cognitively intact. Resident #52 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party.	F 578	Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	

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F 578	Continued From page 7	F 578		

k. Resident #65 was admitted to the facility on 10/20/24. Resident #65 had severe cognitive impairment. Resident #65 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party.

l. Resident #61 was admitted to the facility on 8/23/22. Resident #61 was cognitively intact. Resident #61 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party.

m. Resident #45 was admitted to the facility on 9/12/23. Resident #45 was cognitively intact. Resident #45 held a physician order for full code. There was no documentation in the medical record for education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party.

An interview was conducted with the Social Worker on 11/21/24 at 1:06 PM. The Social Worker stated advance directives were reviewed during the care plan meeting. She stated the review of advance directives was documented on the Care Plan assessment or in the Social Services assessment upon admission and readmission. The Social Worker stated she filled out an advance directive form to show that advance directive was discussed with the

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F 578	Continued From page 8 residents or family during care planning. The Social Worker stated the Advance Directive form was uploaded into the electronic medical record. There was no documentation of education regarding formulation of an advance directive or documentation that an opportunity to formulate an advance directive was offered to the resident or their responsible party on the advance directive form. An interview was conducted with the Administrator on 11/21/24 at 1:30 PM. The Administrator stated the education and discussion of Advanced Directives should have been documented for each resident in the facility. The Administrator stated he expected that residents would be reassessed for advance directives when readmitted and during the care plan meeting.	F 578		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		12/16/24

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§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and

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telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the

The statements made on this plan of

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F 623	Continued From page 11 facility failed to provide written notification for reason of discharge to the Ombudsman for 4 of 6 residents reviewed for hospitalization (Resident #38, Resident #51, Resident #61, Resident #71). The findings included: a. Resident #71 was admitted to the facility on 6/19/2024. Resident #71 transferred to the hospital on 7/15/2024 and returned to the facility on 7/19/2024. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. b. Resident #51 was admitted to the facility on 1/24/2024. Resident #51 transferred to the hospital on 10/18/2024 and returned to the facility on 10/25/2024. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. c. Resident #38 was admitted to the facility on 10/31/2023. Resident #38 transferred to the hospital on 6/15/2024 and returned to the facility on 6/27/2024. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. d. Resident #61 was admitted to the facility on 8/23/2022. Resident #61 transferred to the hospital on 12/21/2023 and returned to the facility on 12/27/2023. Additionally, Resident #61 transferred to the hospital on 9/10/2024 and	F 623	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 The facility failed to provide written notification for reason of discharge to the Ombudsman for 4 of 6 residents 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/09/2024, the Social Service Director provided written documentation for the reason for discharge to the Ombudsman for resident #38, #51, #61, and #71. (will need info sent and confirmation) 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/12/24, the Administrator completed audit for the month of November 2024 to ensure written documentation for discharges was provided to the Ombudsman. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/6/24, the Nurse Consultant provided education to the Social Service Director on written notification to be	

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F 623	Continued From page 12 returned to the facility on 9/12/2024. A record review revealed there was no documentation the Ombudsman received written notification for transfer to the hospital. During an interview with the Social Worker (SW) on 11/19/2024 at 12:58 p.m. she revealed she had not sent discharge information to the Ombudsman's office for those residents who were sent to the hospital. The SW reported she was not aware she had to send written notification to the Ombudsman when a resident transferred to the hospital. During an interview with the Administrator on 11/21/2024 at 10:30 a.m. he revealed he was not aware the SW had not submitted monthly discharge reports to the Ombudsman. He stated it was the responsibility of the SW to send discharge notifications to the Ombudsman.	F 623	provided to the Ombudsman for residents who discharge. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Administrator or designee will audit all Discharges for notification of the Ombudsman for compliance. This monitoring will be completed weekly x 2 weeks and then monthly times 3 months or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		12/16/24

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F 644	Continued From page 13 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with a serious mental illness for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR (Resident #34). Findings included: Resident #34 was admitted to the facility on 11/16/2022 and readmitted on 8/7/2023. On 8/7/2023 Resident #34 was diagnosed with delusional disorder. A Level I PASRR determination notification letter dated 3/3/2020 indicated "No further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." No facility documentation was discovered indicating a Level II PASRR referral had been completed for Resident #34 after the diagnosis of	F 644	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F644 The facility failed to refer a resident with a serious mental illness for a level II Preadmission Screening and Resident review (PASRR) for 1 of 2 residents 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/19/24, the Social Service Director submitted PASRR screen for resident #34 and it was completed 12/11/2024. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 644	Continued From page 14 a serious mental illness had been made. An interview with the Social Worker (SW) on 11/20/2024 at 2:50 p.m. revealed she was not aware Resident #34's Level II PASRR screening had not been completed. She stated the Admissions Director would let her know if a resident required screening. During an interview with the Admissions Director on 11/21/2024 at 9:35 a.m. she revealed she checked residents' PASRR screening upon admission. She explained she had failed to check Resident #34's PASRR upon readmission. After reviewing his diagnosis, she indicated Resident #34 met the criteria for serious mental illness and she should have submitted a referral for a Level II PASRR screening. During an interview with the Administrator on 11/21/2024 at 10:35 a.m. he revealed he was not aware Resident#34's PASRR screening had not been completed upon readmission and explained this was a problem.	F 644	deficient practice. On 12/10/2024, the Director of Nurses completed an audit of the last 30 days of new psychoactive medication orders, and a list was given to the social worker for PASRR screen on 12/10/2024. The social worker completed submission for PASRR review for 3 residents which was completed on 12/12/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/6/24, the Nurse Consultant provided education to the Director of Nurses and the Social Service Director on PASRR- what it is, it□s purpose, and when it is needed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Administrator or designee will audit for compliance of PASRR screens. This monitoring will be completed with 5 residents weekly x 2 weeks and then monthly times 3 months or until resolved. The Director of Nurses will audit for new psychoactive medication orders and/or newly diagnosed mental disorder, intellectual disability, or related condition. This audit will be completed weekly using the order listing report in PCC weekly x 2weeks and then monthly for 3 months or until resolved. Reports will be presented to the monthly Quality Assurance	

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F 644	Continued From page 15	F 644	committee by the Administrator and Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 12/16/2024	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		12/16/24

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F 761	Continued From page 16 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 observation, staff interviews, the facility failed to dispose/discard expired medications in 1 of 3 medication carts (600 Hall medication cart) observed for medication storage. The findings included: An observation was conducted of the 600 Hall medication cart on 11/21/24 at 10:48 AM. One opened bottle of Senna -Plus with an expiration date of October 2024 was found on the cart. An interview was conducted with Medication Aide #2 on 11/21/24 at 10:50 AM. Mediation Aide #2 stated the medication should have been discarded. Medication Aide #2 stated the medication aide/ nurse assigned to the cart was responsible for checking for expired medications each shift. An interview was conducted with the Director of Nursing (DON)on 11/21/24 at 11:28 AM. The DON stated the medication aides and nurses assigned to the medication cart were responsible for checking carts for expired medication. The DON stated expired medications were to be removed from the cart immediately. An interview was conducted with the Administrator on 11/21/24 at 1:28 PM. The Administrator stated the medication aides and nurses assigned to the medication cart were	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 The facility failed to dispose/discard expired medications in 1 of 3 medication carts (600 Hall medication cart) 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/21/24, the medication aid #2 disposed of Senna-Plus dated 10/2024. On 11/21/24, the DON re-educated Medication aide #2 on medication storage policy and disposal of any expired medication observed on medication carts. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/21/24, the DON and unit managers conducted 100% cart audits for expired medications. No other expired medications found.	

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F 761	Continued From page 17 responsible for checking carts for expired medication. The Administrator stated expired medications were to be removed from the cart immediately.	F 761	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/21/24, the DON began education of all FT, PT, PRN and Agency Nurses, Medication Aides on Medication Storage and expired. The education was provided: Medication storage policy and Recommended Maximum Storage on selected Items. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 12/13/24 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The DON and/or designee will monitor medication carts to assure that expired medications are disposed of as appropriate. Monitoring of 2 medication carts will be completed 2 x per week for 2 weeks, weekly x 2 and then monthly x 3 or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality	

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F 761	Continued From page 18	F 761	Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 12/16/2024	