| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE LAURELS OF FOREST GLENN | 1101 HARTWELL STREET GARNER, NC 27529 |

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| E 000 | Initial Comments<br><br>The survey team entered the facility on 05/06/2025 to conduct a recertification and complaint investigation survey. The survey team was onsite 05/06/2025 through 05/09/2025. Additional information was obtained offsite on 05/12/2025. Therefore, the exit date was 05/12/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #27B711 | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>The survey team entered the facility on 05/06/2025 to conduct a recertification and complaint investigation survey. The survey team was onsite 05/06/2025 through 05/09/2025. Additional information was obtained offsite on 05/12/2025. Therefore, the exit date was 05/12/2025. Event ID #27B711.<br><br>The following intakes were investigated: NC00226787, NC00228640, NC00226278, and NC00224408.<br><br>1 of the 12 complaint allegations resulted in deficiency. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of hospice care for 2 of 21 residents reviewed for | F 641 | The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance. | 5/29/25 |

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

Electronically Signed | 05/30/2025

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| F 641 | Continued From page 1<br>MDS accuracy (Resident #17 and Resident #87).<br><br>Findings include:<br><br>1. Resident #17 was admitted to the facility on 12/19/22. Her diagnoses included senile degeneration of the brain, chronic diastolic heart failure, and chronic respiratory failure with hypoxia.<br><br>Resident #17's care plan had a care focus area created 9/2/24 that indicated Resident #17 was receiving hospice services.<br><br>A physician order dated 8/26/24 indicated Resident #17 was a hospice recipient since 8/24/24.<br><br>Resident #17's quarterly MDS dated 2/26/25 did not indicate Resident #17 was receiving hospice care.<br><br>During an interview with the MDS Nurse on 5/9/25 at 9:08 AM, she stated that Resident #17 was receiving hospice services, and it should have been coded on the quarterly MDS. The MDS Nurse further stated that it was an oversight.<br><br>An interview was conducted on 5/9/25 at 11:41 AM with the Director of Nursing (DON). The DON stated that Resident #17's MDS should have been coded correctly to reflect the Resident's status. She indicated Resident #17's quarterly MDS should have included hospice care since she was receiving hospice services.<br><br>During an interview on 5/9/25 at 12:19 PM, the facility Administrator verbalized he expected | F 641 | Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.<br><br>Corrective Actions for identified residents: 2 Residents out of 21 reviewed were coded inaccurately for the election of Hospice Services. Residents #17 & #87 were corrected 5-8-25 by the Director of MDS.<br><br>Identification of other residents having the potential to be affected by the deficient practice: All residents have the potential to be affected by this alleged deficient practice if they have elected Hospice. An audit of all current residents on Hospice was completed on 5-8-25 by the Director of MDS. Corrections made as needed for MDS to be accurate.<br><br>Measures put into place or systemic changes made to ensure deficient practice will not recur: Education was completed for MDS Staff on appropriate coding for Hospice residents on 5-8-25 by Administrator with support from Regional MDS Director. An Audit Tool will be created to include verification of Hospice Services including MDS updates to reflect. Director of MDS, or 2nd seat MDS will complete the audit tool after hospice is | |

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| F 641 | Continued From page 2<br>Resident #17's MDS to be coded correctly to include hospice care.<br><br>2. Resident #87 was admitted to the facility on 6/13/23. Her diagnoses included dementia, and hypertensive heart disease.<br><br>Resident #87's care plan had a care focus area created 12/24/24 that indicated Resident #87 was receiving hospice services.<br><br>A physician order dated 12/23/24 indicated Resident #87 was a hospice recipient since 12/21/24.<br><br>Resident #87's quarterly MDS dated 3/5/25 did not indicate Resident #87 was receiving hospice care.<br><br>During an interview with the MDS Nurse on 5/9/25 at 9:08 AM, she stated that Resident #87 was receiving hospice services, and it should have been coded on the quarterly MDS. The MDS Nurse further stated that it was an oversight.<br><br>An interview was conducted on 5/9/25 at 11:41 AM with the Director of Nursing (DON). The DON stated that Resident #87's MDS should have been coded correctly to reflect the Resident's status. She indicated Resident #87's quarterly MDS should have included hospice care since she was receiving hospice services.<br><br>During an interview on 5/9/25 at 12:19 PM, the facility Administrator verbalized he expected Resident #87's MDS to be coded correctly to include hospice care. | F 641 | selected by residents. Completed 5-29-25.<br><br>How Facility will monitor performance to make sure solutions are sustained: MDS will report to QAPI monthly on audits showing updates to MDS for hospice residents to include correct coding in MDS. The audits will be completed by the Director of MDS and or 2nd Seat MDS. 1 X weekly X 8 weeks. Then the audit will then be completed 1 X monthly for 2 months. After 4 months if compliance has been obtained and maintained, the QAPI committee can discontinue the audit process. | |

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| F 689 | Continued From page 3 | F 689 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff and Medical Director interviews, the facility failed to provide services in a safe manner when the Certified Occupational Therapy Assistant (COTA) utilized a rollator (a four wheeled walker with a seat) during a therapy session which had been deemed unsafe for Resident #313. During a therapy session with COTA #1 on 11/9/24 Resident #313 stood up from the locked rollator, unlocked brakes, and while turning herself around to walk forward, she fell to her left against the counter/lower kitchen cabinets and slid down to the floor. Resident #313 was sent to the emergency department (ED) on 11/9/24 for evaluation after reporting pain in her left shoulder and hip. A computerized tomography (CT) scan of the pelvis revealed a nondisplaced left greater trochanter fracture (break at the top of the thigh bone near the hip). Orthopedics was consulted and recommended nonoperative management and Resident #313 was admitted for inpatient care for further evaluation and pain management due to uncontrolled pain. Resident #313 was discharged from the hospital back to the facility on 11/13/24 with orders that included weight bearing as tolerated, ambulation with rolling | F 689 | The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.<br><br>Corrective Actions for identified Resident:<br>Resident #313 was sent to Emergency department same day after fall due to complaints of pain. Resident #313 was readmitted to facility on 11/13/24. Hospital interventions were identification of a non displaced fx to Left Femur. Resident received non operative management with weight bearing as tolerated and ambulation with rolling walker from hospital with assist. Rehab | 5/29/25 |

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| F 689 | Continued From page 4<br>walker, scheduled Tylenol for pain, lidocaine patch to left hip topically one time a day for pain, oxycodone (opioid pain medication) every 6 hours as needed for pain and rehabilitation services at a skilled nursing facility. The deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #313).<br><br>The findings included:<br><br>Resident #313 was admitted to the facility on 8/5/24. Her diagnoses included diabetes, chronic obstructive pulmonary disease and generalized muscle weakness.<br><br>An OT evaluation dated 10/30/24 included a section titled functional skills assessment - mobility during activities of daily living (ADLs) that indicated wheelchair mobility was stand by assist, wheelchair management was standby assist and other functional mobility during ADLs was moderate assistance.<br><br>A review of Resident #313's medical records revealed a physical therapy treatment encounter note completed on 11/11/24 with a date of service of 10/31/24. The summary of skill section indicated skilled interventions focused on gait training using a rollator as per Resident's request during her meeting with Director of Rehabilitation. Resident #313 wanted therapist to train her to ambulate with a rollator so she could carry her oxygen tank in the basket as she was adamant about going home. Gait training with Rollator for 15 feet x 2 with minimum/moderate assist on level surface. Resident unable to keep up with rollator speed despite instructions to use rollator brakes. Resident also stated that she could stop and sit on the rollator seat if she gets tired. | F 689 | services completed an evaluation on 11/14/24 with POC set as weight bearing as tolerated, ambulation with rolling walker with standby assist/contact guard. Resident #313 was discharged on 12/16/24 to home per residents request. Resident was able to ambulate with front wheel walker 40 to 70 feet with standby assist/contact guard. PT, OT and CNA care was setup prior to discharge for home needs along with a wheelchair for residents use.<br><br>Identification of other areas having the potential to be affected by the deficient practice: All residents on therapy caseload have the potential to be affected by the alleged deficient practice. An audit was completed for all residents on therapy caseload by the Director of Rehab on 5/9/25, to identify any residents using a mobility device that was deemed unsafe by Physical Therapist or Occupational Therapist, to ensure residents are not using the identified unsafe device. No other residents were identified as using a mobility device deemed unsafe.<br>Measures put into place or systemic changes made to ensure deficient practice will not recur: The facility will continue to ensure that mobility devices utilized and deemed unsafe for residents use, will not be used. Physical Therapist Assistant or Certified Occupational Therapist Assistant will continue to follow Plan of Care given by Occupational Therapist and or Physical Therapist and seek direction from Physical Therapist and or Occupational Therapist as needed | |

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| F 689 | Continued From page 5<br>Therapist demonstrated safe transfer technique from ambulating to sitting (rollator seat). Resident lost her balance while in the process of turning in preparation to sit on her rollator (after she locked rollator brakes). Therapist explained safety concerns with her using a rollator. Resident verbalized understanding.<br><br>A physical therapy treatment encounter note completed on 11/11/24 with a date of service of 11/1/24 included a summary of skills that indicated skilled intervention focused on gait training with Rollator for 10 feet + 16 feet with minimum/moderate assist on level surface. Resident #313 noted to lose balance after left foot catching on floor. Therapist explained safety concerns regarding use of rollator. Resident verbalized understanding.<br><br>A physical therapy treatment encounter note dated 11/9/24 at 11:38 AM included a summary of skills that indicated gait training with a two-wheel walker and wheelchair follow for oxygen transport. 8 bouts of 20 to 30 feet gait training with contact guard assist with min verbal cues position to assistive device with fatigue and change in direction. With fatigue, increased distance from assistive device and increased instability. Cues for position to surface prior to turn to sit for appropriate targeting and to limit retro (backward)walking. Educated Resident and nursing staff related to ongoing falls risk and need for assist with standing and ambulation for falls prevention at this time.<br><br>A physical therapy discharge summary dated 11/11/24 included a summary since evaluation/start of care section that indicated Resident #313 progress and response to | F 689 | when a resident requests to use an unsafe mobility device.<br><br>How Facility will monitor performance to make sure solutions are sustained: Education was provided to all Rehab Staff on 5/9/25 by the Director of Rehab to ensure mobility devices that have been deemed unsafe will not be utilized. An audit tool was created on 5/9/25 to track PT and OT Plan of Care that identify mobility devices that are unsafe for residents use. The audits will be completed by the Director of Rehab. Frequency shall be 1 X Weekly for 2 months, 1 X monthly for 2 months to ensure compliance is obtained and maintained. Audit results will be reported monthly to QAPI Committee by the Director of Rehab for review and actions as needed to ensure compliance. After 4 months, the QAPI Committee can discontinue the audits if compliance has been obtained and maintained. | |

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| F 689 | Continued From page 6 | F 689 | | |

treatment was that Resident had made substantial functional gains in response to skilled interventions including ambulating with front wheel walker to minimum assistance/contact guard assist. Functional outcomes indicated the assistive device was a front wheeled walker.

During an interview on 5/7/25 at 12:07 PM, the Director of Rehabilitation indicated she was a physical therapist (PT). The Director of Rehabilitation stated that Resident #313's level of function was a front wheel walker, and a wheelchair as indicated on Resident #313's physical therapy discharge summary dated 11/11/24 as well as documented on the physical therapy treatment encounter note dated 11/9/24. The Director of Rehabilitation verbalized that she had informed Resident #313 on 10/30/24 during a meeting for potential discharge that the rollator with four wheels was not safe for her. She further stated that Resident #313 required standby assistance from sit to stand position and with functional transfers. The Director of Rehabilitation verbalized that she would not have told COTA #1 to train Resident #313 on the rollator because she was not her immediate supervisor.

Resident #313's quarterly Minimum Data Set (MDS) Assessment dated 11/6/24 coded the resident as cognitively intact and required partial to moderate assistance with rolling in bed, sitting to standing, transfers, walking 10 feet and walking 50 feet with two turns. Resident #313 was also coded for a walker and wheelchair for mobility devices.

A review of Resident #313's medical records revealed an occupational therapy treatment encounter note dated 11/9/24 written by Certified

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Occupational Therapy Assistant (COTA) #1. The note indicated a plan was made with Resident #313 to address simple meal preparation in the therapy kitchen as Resident still reported intent to return home alone this week. Resident reported that she was told by a therapist that she would need to go home with oxygen and that she would be safest with a rolling walker (RW) and would be unsafe with a rollator, because "it'll get away from me". Resident was asked what her revised plan would be, as Resident had repeatedly stated, her plan was to go home using a rollator in the home, despite having a RW, and that the size of her living area would not support a wheelchair (WC). Resident stated once again that she would still be using a rollator at home, despite therapist education, stating, "Well that's their opinion." Resident asked therapist if she could demonstrate the way she intended to use her rollator at home in her kitchen. Resident was educated in management of rollator brakes, ambulating with standby assistance (SBA), then sitting on seat of therapy rollator, using it as a WC to propel around from kitchen cabinets to refrigerator to stove, removing items from bottom cabinet seated on rollator. Resident educated on proper use of rollator as a walking aid, not to be used as a WC due safety concerns. Resident then stood up from the locked rollator, unlocked brakes, while turning herself and rollator around to walk forward, she fell to her left against the counter/lower kitchen cabinets and slid down to the floor. Therapist provided Resident with a pillow for her head and alerted nursing staff who came to evaluate the Resident and lift the Resident from the floor into the WC. Resident then agreed that the use of a rollator for her was not a good option. Resident had a small skin tear and stated that she needed to go to the hospital

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| F 689 | Continued From page 8 | F 689 | | |

due to pain in her left shoulder and hip.

An interview was conducted with COTA #1 on 5/8/25 at 8:38 AM. She indicated that she was aware that Resident #313's safest level of function was a front wheel walker (FWW) also known as a rolling walker and a wheelchair (WC) and not a rollator which had 4 wheels. COTA #1 stated that Resident #313 had told her that when she discharged home, she was going to use a rollator and she informed the Resident that it was not safe, and the Resident stated that was the opinion of the therapist. COTA #1 verbalized she asked Resident #313 to show her how she intended to use the rollator when she went home. COTA #1 pushed Resident #313 from her room to the therapy room so that she could demonstrate how she would use the rollator. She stated that her intention was not to make the rollator use a full training session but to show Resident #313 that it was not safe for her. She stated that her goal was to get Resident #313 away from using the rollator and to agree to use the front wheel walker and WC which were safe for her and that Resident #313 realized that the rollator was not safe for her after she fell. COTA #1 stated she did not ask the OT or anyone else if she should train Resident #313 to use the rollator because she was not planning to make it a full training session. She stated that she did not realize that the Resident was going to use the rollator as a wheelchair. COTA #1 stated that after she wheeled Resident #313 to the therapy room she placed the rollator in front of the Resident. Resident #313 stood up from the wheelchair and walked to the rollator that was in front of her and she sat on the rollator and COTA #1 informed the Resident not to use the rollator as a wheelchair. COTA #1 stated she then turned to the cabinet

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| F 689 | Continued From page 9 | F 689 | | |

and in that process Resident #313 stood up from the rollator, unlocked the rollator and was turning herself to move when she fell against the cabinet. She informed nursing staff who came to assess the Resident and transfer the Resident to the wheelchair.

An interview was conducted on 5/8/25 at 9:38 AM with the facility Occupational Therapist (OT). The OT indicated she had evaluated Resident #313 on 10/30/24 and the short-term goals included toileting transfers, lower body bathing, and lower body dressing. The long-term goals included lower body dressing, bathing and toileting with modified independence and simple meal preparation with modified independence in order to return home safely. The OT explained that the OT completed the evaluation and came up with goals which the COTA implemented. She stated that she trusted the COTA's clinical judgement to determine what is safe for a resident and if the COTA wanted to try a device, she would expect the COTA to communicate with her. She stated COTA #1 did not communicate to her that she was going to train Resident #313 to use the rollator and that it was a weekend and she was not at the facility on that day. The OT verbalized that the recommended safety level for Resident #313 was the front wheel walker, and that she had not told COTA #1 at any point to train Resident #313 to use the rollator. The OT stated that the rollator was not safe for Resident #313 because the rollator had four wheels and could roll away faster than a front wheel walker which had only 2 wheels. She further stated physical therapy had determined that the rollator was not safe for Resident #313.

A nursing note dated 11/9/24 indicated at around

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| F 689 | Continued From page 10 | F 689 | | |

1:30 pm Resident #313 fell on her stomach, while walking with the rollator in the therapy room witnessed by occupational therapy staff. Resident #313 complained of pain to the left hip and left shoulder. Tylenol was given as ordered, provider was made aware with new orders given for x-ray to left hip and left shoulder and Responsible Party (RP) was made aware.

A nursing note dated 11/9/24 indicated Resident #313 was sent to the emergency department (ED) at around 3:55 PM for further evaluation.

During an interview with Nurse #1 on 5/12/25 at 2:00 PM, she indicated she was assigned to care for Resident #313 on 11/9/25 on day shift. She stated that she was notified by a staff member that Resident #313 had fallen while working with therapy staff. She went to the therapy room and found Resident # 313 lying on the floor facing down and she was complaining of pain to her left side. Nurse #1 stated that they transferred Resident #313 with the assistance of 4 staff members to the wheelchair and she notified the provider who gave an order for x-rays, but the x-rays were not completed because Resident # 313 requested to be sent to the ED and Nurse # 1 notified the provider and the Resident was sent to the ED. Nurse #1 verbalized that nursing staff utilized the wheelchair for Resident #313 and she had treatment sessions with physical therapy where they were walking with her but she could not tell exactly what kind of walker she was using for ambulation when working with therapy.

ED progress notes dated 11/9/24 indicated Resident #313 was seen at the ED after a fall while walking at a skilled nursing facility and complained of pain. A computerized tomography

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| THE LAURELS OF FOREST GLENN | 1101 HARTWELL STREET GARNER, NC 27529 |

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(CT) scan of the pelvis revealed a nondisplaced left greater trochanter fracture. Consultation with orthopedics recommended nonoperative management and Resident #313 was admitted for inpatient care for further evaluation and pain management due to uncontrolled pain. Prior to inpatient admission Resident #313 was started on as needed pain medicine Toradol and fentanyl at the ED. Upon admission for in patient care she was started on scheduled Tylenol, as need oxycodone, lidocaine patch to the left hip and as needed Robaxin (muscle relaxant). Resident #313 was discharged from the hospital back to the facility on 11/13/24 with orders that included weight bearing as tolerated, ambulation with rolling walker, scheduled Tylenol 500 milligram 4 times a day for pain, lidocaine patch to left hip topically one time a day for pain, oxycodone 5 mg every 6 hours as needed for pain and rehabilitation services at a skilled nursing facility. Her discharge diagnoses included closed trochanter fracture of the left femur with routine healing and hip pain.

An interview was conducted on 5/9/25 at 10:42 PM with the facility Medical Director (MD). The MD stated that COTA #1 should not have used the rollator with Resident # 313 because it was not part of OT's treatment plan and it had been determined unsafe. He also stated that if it was for demonstrative purposes, then it should have been done in a safe manner.

During an interview on 5/9/25 at 12:07 PM with the Director of Nursing (DON), she stated that COTA #1 should have verified with OT if she should use the rollator with Resident #313 if it had been deemed unsafe for the Resident.

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| F 689 | Continued From page 12<br>During an interview with the facility Administrator on 5/9/25 at 12:30 PM, he indicated that his expectation was for the COTA to work with the Resident at a safe functional level for the Resident. | F 689 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to discard an opened canned drink in 100-hall nourishment room refrigerator and label and date food items stored in the 200-hall nourishment room refrigerator for 2 of 2 nourishment room refrigerators (100-hall and 200-hall nourishment room refrigerators).<br><br>Findings included: | F 812 | The Laurels of Forest Glenn wishes to have this submitted plan of correction stand as its written allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity | 5/29/25 |

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| F 812 | Continued From page 13<br><br>Observation of the nourishment room refrigerators with the facility's Dietary Manager (DM) on 5/8/25 revealed the following:<br>a. An open energy drink can with some liquid in it and a straw was observed in the 100-hall nourishment refrigerator at 12:34 PM. The energy drink can was not labeled or dated. The DM discarded the energy drink.<br><br>b. Two pizza boxes, one with 1/4 pizza and the other one with half a pizza were observed in the 200-hall nourishment refrigerator at 12:40 PM. The pizza boxes were not labeled or dated.<br><br>The Dietary Manager, who was present during the observations, stated that nursing staff were supposed to ensure the food items were labeled and dated before being placed in the refrigerator.<br><br>An interview was conducted on 5/8/25 at 12:42 PM with the Director of Nursing (DON) when she came into the 200-hallway nourishment room and placed the food items in the trash can. The DON stated that nursing staff should have labeled and dated the food items before placing them in the fridge. The DON further stated the energy drink should not have been placed in the refrigerator after it was opened.<br><br>An interview was conducted with the facility Administrator on 5/9/25 at 12:29 PM. The Administrator stated that his expectation was for all foods to be labeled and dated before being placed in the nourishment room refrigerators and opened drinks should not have been placed in the refrigerator. | F 812 | of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.<br><br>Corrective Actions for identified areas of concern: 2 of 2 Nourishment Room Refrigerators had unlabeled and dated items in them. Items were removed from the nourishment room refrigerator by the Director of Nursing that were not labeled and dated. Corrected 5/8/25.<br><br>Identification of other areas having the potential to be affected by the deficient practice: 2 of 2 of the Nourishment Room Refrigerators have the potential to be affected by the alleged deficient practice.<br><br>Measures put into place or systemic changes made to ensure deficient practice will not recur: Education will be provided to all Staff on Labeling and Dating of all items placed in the nourishment room refrigerators by the Director of Nursing, Assistant Director of Nursing and or Unit Managers. Completed by 5/29/25. New hire process has been updated to included the education for labeling and dating of items in Nourishment Room Refrigerators. For staff not available Paid Time Off, have not worked since education started, etc they are being required to complete education before working their next shift. Audits will be completed by Director of Nursing or Assistant Director of Nursing or the Unit Managers. | |

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| F 812 | Continued From page 14 | F 812 | Audits will be completed 1 X weekly X 2 months. If compliance is obtained, the audits will then be completed 1 X monthly X 2 months.<br><br>How Facility will monitor performance to make sure solutions are sustained: Audits will be reported to QAPI monthly by the Director of Nursing and or Assistant Director of Nursing, to ensure compliance is obtained/maintained with needed actions as necessary to ensure compliance. After 4 months if compliance has been obtained/maintained, the QAPI committee can discontinue the audit process. | |