STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 09/28/2023

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HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(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 were conducted on 9/25/23 through 9/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Z0ZY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 9/25/23 through 9/28/23. Event ID# Z0ZY11. The following intakes were investigated NC00206956, NC00199908, NC00202876, NC00195425, NC00206868, NC00196813, and NC00205706. 20 of the 20 complaint allegations did not result in a deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/26/23

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

Electronically Signed | 10/20/2023

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, staff interviews and observations, the facility failed to provide a room free of a strong smell of urine. This was evident in 1 of 5 rooms reviewed for clean, homelike environment (Room 226). Findings included: Resident #10 was admitted in the facility on 12/13/13 with the most recent readmission on 10/11/22. The quarterly Minimum Data Set (MDS) assessment dated 7/20/23 revealed Resident #10 was cognitively intact. Resident #10 was independent with toilet use and required	F 584	F584: Safe/Clean/Comfortable Homelike Environment 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice " On 9/28/23, the Environmental Service Manager deep cleaned the room of Resident #10 room to ensure free from odor (of urine smell). 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: " 100 % audit of all resident rooms utilizing the Resident Room Rounds audit tool by Environmental Service Manager or	

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F 584	Continued From page 2 oversight, encouragement or cueing with personal hygiene with one-person physical assist. Resident #10 required one-person physical assist with bathing with physical help limited to transfer only. A review of Resident #10's care plan dated 4/20/23 revealed Resident #10 "Resident sometimes resisted/refused care which may compromise health/ safety/ well-being. Often refused baths and personal hygiene care. Also sometimes refused to allow laundry to wash dirty clothes or allow staff to move dirty clothes piled on the floor. Refused to be evaluated by psych services and medical MD's multiple times." Interventions included to approach resident warmly and positively to convey acceptance, warmth, and welcome and speak in a calm, gentle manner, to provide positive feedback for demonstrating desired behaviors/cooperation with staff and assess for uncommunicated/unmet needs when behaviors occur such as hunger, thirst, pain, and toileting needs and provide appropriate interventions. Interventions also included to "be aware resident sometimes refused room rounds to ensure cleanliness of room, identify unsafe situations of presence of inappropriate items. Explain this is for their well-being/comfort and safety and encourage compliance." In addition. resident was very reclusive and didn't want anyone to handle her things. The care plan addressed Resident #10 had occasional bladder incontinence due to her impaired mobility, dependence on staff, increased weakness, and decreased endurance presented a barrier to independent toileting activities. An intervention for bladder incontinence included to utilize disposable briefs to prevent soiling of clothing/ bed linens and reduce risk for skin	F 584	designee for odors on 10/18/23. Any issues identified immediately corrected by Environmental Service Manager or designee on 10/18/23. " Any identified resident rooms with odors were deep cleaned by Environmental Service Manager on 10/18/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " On 9/29/23, Executive Director implemented the use of Resident Room Rounds audit tool to be completed by IDT team daily. " 100% IDT education on the process enhancement of Resident Room Rounds audit tool by Director of Operations on 9/29/23. " By 10/18/23 hall staff, such as NA1 and Nurses, will be educated to report any concerns related to room odors to the ED/DNS or designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained " As a monitoring tool, Executive Director will discuss any identified concerns on the Resident Room Rounds audit during daily IDT (stand-down) meeting on 10/16/23. " 100% review of resident room environmental audit by Executive Director will be conducted during the daily morning meeting x 4 weeks, monthly x 4 weeks, monthly x 3 months and quarterly thereafter to monitor for safe, clean and	

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F 584	Continued From page 3 issues. An observation on 9/25/23 at 2:20 PM of room 226 was conducted in conjunction with an interview with Resident #10 who resided in the room. The observation revealed the room smelled strongly of urine from the doorway into the hallway. The bathroom door was open, and the bathroom was observed to be neat and clean. The resident in the bed closest to the window (Resident #10) stated she was continent of bladder but wore a "pull up" for incontinent episodes. The odor of urine was pungent on Resident #10's side of the room. She said she tried to make it to the bathroom when she needed to urinate but had been incontinent at times. An observation on 9/26/23 at 11:44 AM of room 226 was conducted in conjunction with an interview with Resident #10 who resided in the room. The observation revealed the room smelled strongly of urine from the doorway into the hallway. Resident #10 stated housekeeping cleaned the room once a day and the facility did her laundry. She stated she wore "pull ups" for incontinence episodes. On 9/26/23 at 12:00 PM an interview with the Laundry and Housekeeping Manager revealed housekeeping deep cleaned room 226 bimonthly. Resident rooms were swept and mopped daily, and hard surfaces were disinfected daily. She stated, to her knowledge, Resident #10 had not refused to have her room cleaned. On 9/26/23 at 12:03 PM an interview with Housekeepers #1 and #2 revealed Resident #10 did not refuse to allow room to be cleaned. They stated that they cleaned and mopped the room	F 584	comfortable environment. (10/17/23) " Audit Compliance will be discussed weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. (10/17/23) The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	

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F 584	Continued From page 4	F 584		

daily, but it still smelled of urine due to Resident #10's incontinence episodes.

On 9/26/23 at 12:08 PM an interview with Nurse Aide #3 (NA) revealed she had worked at the facility for 18 years and was usually assigned to Resident #10. She stated Resident #10 would not allow staff to assist her with care because she wanted to be independent. She further stated Resident #10 refused showers because she was very private and preferred to bathe herself in the bathroom sink. She added Resident #10 would not give staff the soiled pad from her bed unless staff had a clean one to provide her. NA #1 added when Resident #10 refused to shower this morning she got NA #4 to try but Resident #10 still refused.

An interview with NA #4 on 9/26/23 at 12:12 PM revealed she had worked at the facility for two years and was familiar with Resident #10. She stated that NA #3 had asked her to try to convince Resident #10 to shower but she had refused. Resident #10 was offered a bed bath and she refused.

On 9/28/23 at 10:45 AM an observation of room 226 was conducted in conjunction with an interview with the Staff Development Coordinator (SDC). Upon entering the room there was no odor of urine noted. The SDC and housekeeping staff were observed in the process of cleaning Resident #10's room. Staff moved furniture and boxes and swept and mopped under them. The waste basket next to Resident #10's bed was clean with a fresh liner. The SDC stated Resident #10 often refused to leave her room so that staff could clean but had agreed to attend activities and allow staff to clean the room this day. She

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F 584	Continued From page 5 explained Resident #10 was very independent and preferred to bathe herself in the sink rather than shower. On 9/28/23 at 10:46 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #10 was adamant she could care for herself and had a right to refuse up to a point. She explained Resident #10 had agreed to palliative care because of her refusal of care and refusal to allow staff to clean her room and linens. She stated she expected Resident #10's room to be clean and free of odors. She explained she expected staff to reapproach Resident #10 often to see if she would allow more assistance with her care and cleanliness.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Hospice/End of life care (Resident #74) and discharge location (Resident #85). This occurred for 2 of 23 residents reviewed for accuracy of assessments. The findings included: 1. Resident #74 was admitted to the facility on 4/27/23 with a cumulative diagnosis which included heart failure and a history of a cerebrovascular accident (stroke). The resident's	F 641	F641: Accuracy of Assessments CFR(s): 483.20 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice • On 9/28/23, it was identified during the survey process that facility failed to accurately code resident assessment as Hospice and failed to accurately code resident assessment for accurate discharge location of another resident. • Inservice of process and accuracy of assessment code requirement was	10/26/23

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F 641	Continued From page 6 admission Minimum Data Set (MDS) was dated 5/3/23. A review of the resident's electronic medical record (EMR) revealed her physician orders included a Hospice consult on 5/9/23. A significant change MDS assessment dated 5/9/23 was completed for resident #74. However, review of this MDS revealed the section on "Health Conditions" did not indicate the resident had a life expectancy of less than 6 months. Also, the MDS section on "Special Treatments, Procedures and Programs" did not indicate Resident #74 was receiving Hospice services. An interview was conducted on 9/28/23 at 4:03 PM with the facility's MDS Nurse. When asked what prompted the significant change MDS to be completed for Resident #74 on 5/9/23, the nurse reported it was completed due to the resident's admission to Hospice on 5/9/23. Upon further inquiry, the MDS Nurse reviewed the Section J and Section O of the resident's MDS assessment. At that time, the MDS Nurse reported Section J should have indicated Resident #74's life expectancy was less than 6 months and Section O should have indicated the resident was on Hospice. The MDS Nurse acknowledged these two pieces of information had been miscoded and reported she would submit a correction for them. 2. Resident #85 was admitted to the facility on 4/5/2023. A review of the electronic record for Resident #85 documented he was discharged on 7/26/2023 to a non-Medicare/Medicaid bed at the facility.	F 641	completed by Director of Clinical Operations on 9/29/23. • MDS Coordinator corrected the assessments for Resident #74 to accurately reflect resident as Hospice and corrected the discharge assessment for resident #85 to non-Medicare/Medicaid bed on 9/28/23. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: • Inservice of process and accuracy of assessment requirement by Director of Clinical Operations on 9/29/23. See Previous • 100% audit on 10/18/23 was conducted of Hospice assessments by the Director of Clinical Reimbursement on all assessments transmitted since 6/28/23, corrections made if needed. • 100% audit on 10/18/23 was conducted of discharge assessments by the Director of Clinical Reimbursement (DCR) on all assessments transmitted since 6/28/23 to ensure accurately reflects resident's status. • Any inaccuracies identified on the assessments during the audit were corrected by the DCR/designee by 10/17/23 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur • 100% audit on all Hospice and significant change assessments transmitted to ensure accurately reflects residents status was completed by 10/18/23. See above	

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F 641	Continued From page 7 A review of the discharge MDS assessment, dated 7/26/2023, documented Resident #85 was discharged to an acute care hospital. An interview was conducted with the MDS Coordinator on 9/28/2023 at 3:06 p.m. and she reviewed the MDS discharge assessment, dated 7/26/2023, for Resident #85. She revealed the Resident had been discharged to a non-Medicare/Medicaid bed at the facility and the discharge to the hospital was not accurate. An interview was conducted with the Administrator on 9/28/2023 at 3:18 p.m. and he revealed it was his expectation that all MDS assessments be completed accurately.	F 641	• 100% audit on all discharge assessments transmitted to ensure accurately reflects resident's status was completed by 10/18/18. See above • The MDS coordinators received in-service training by the Director of Clinical Operations on the MDS Coordinator requirements to ensure compliance with MDS accuracy on 9/29/23 to ensure process implementation. (a) RN MDS Coordinators will ensure all assessments accurately reflect the residents current status through review of significant changes. RN MDS Coordinators will also ensure all assessments accurately reflect the resident's status through review of discharge plan of care and recapitulation of stay completed in partnership with the IDT team. (b) RN MDS coordinators will participate in daily clinical and IDT meetings to ensure that any significant changes and identified discharge changes are updated on the MDS and Care Plan to reflect Accuracy of Assessments. (c) RN MDS will update assessments for accuracy based on residents status. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained • As a monitoring tool, weekly audits of residents on hospice/sig change or identified with a significant change will be conducted by designee x 4 weeks, monthly x 3 months, and quarterly thereafter to monitor any significant changes that would require MDS code reassessment and /or review. • As a monitoring tool, weekly audits of	

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F 641	Continued From page 8	F 641	resident discharge will be conducted by designee x 4 weeks, monthly x 3 months, and quarterly thereafter to monitor any activities that would require MDS code reassessment and/or review. • Audit Compliance will be discussed weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. • The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		10/26/23

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F 656	Continued From page 9 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to implement a comprehensive fall prevention care plan for a resident (Resident #67) with a history of falling. This occurred for 1 of 2 residents reviewed for falls.	F 656	F656: Develop/Implement Comprehensive Care Plan 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice	

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F 656	Continued From page 10 The findings included: Resident #67 was admitted to the facility on 12/3/2020 with diagnoses that included hemiplegia, cerebral infarction, and convulsions. A review of the annual comprehensive Minimum Data Set (MDS) assessment, dated 6/27/2023, revealed Resident #67 had severe cognitive impairment, required extensive assistance of one staff member for bed mobility, and total assistance of two staff members for transferring. She had no documented falls since the prior assessment. A review of the comprehensive care plan, dated 6/27/2023, identified a focus area that read; Resident #67 was at risk for falls related to multiple factors including her cerebral vascular accident, hemiplegia, increased weakness, decreased endurance, decreased safety awareness, lack of coordination, and cognitive deficits. The interventions included: 1. A fall mat beside the bedside that was started on 6/2/2021. 2. Do not leave the Resident in the room unattended when up in the wheelchair and was started on 1/9/2021. 3. Provide a scoop mattress for the bed and was started on 1/29/2021. A review of the most recent fall incident report history for Resident #67 revealed she experienced an unwitnessed fall from the bed on 7/18/2023. An observation was conducted of Resident #67 on 9/25/2023 at 3:14 p.m. sitting in her	F 656	" On 9/28/23, it was identified during the survey process that facility failed to accurately implement a comprehensive fall prevention care plan for resident with history of falling. " Inservice of process and accuracy of Care Plans was completed by Director of Clinical Operations on 9/29/23. " MDS Coordinator corrected the Care Plan for Resident #67 to accurately reflect resident as fall risk and current interventions. 2) Address the facility will identify other residents having the potential to be affected by the same deficient practice: " Inservice of process and accuracy of Care Plan requirement by Director of Clinical Operations on 9/29/23. See above " 100% audit of all residents with history of falling was conducted on 9/28/23 by Director of Clinical Reimbursement Services or designee to ensure all Care Plans reflected up to date interventions. " 100% audit of all residents with history of falling to ensure comprehensive fall prevention plan was implemented conducted on 10/18/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur " 100% MDS coordinators received in-service training by the Director of Clinical Operations on the MDS Coordinator requirements to ensure compliance with MDS development, implementation and comprehensive care	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(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
F 656	Continued From page 11 wheelchair and the bed did not have a scoop mattress. She was alone in the room. An observation was conducted of Resident #67 on 9/26/2023 at 10:50 a.m. sitting in her wheelchair and a scoop mattress was not on the bed. She was alone in the room. An observation was conducted of Nursing Assistant (NA) #1 and #2 on 9/27/2023 at 3:06 p.m. as they provided assistance, using a mechanical lift, to transfer Resident #67 from the wheelchair to the bed. The Resident was placed onto a non-scooped mattress with no positioning devices. The two NA's then asked the resident if they could assist her anymore and went to exit the room. An interview was conducted with NA #1 and NA #2 on 9/27/2023 at 3:10 p.m. and they stated they were finished conducting care. They both were asked if the Resident was on a scoop mattress and they replied, "No." The two stated they did not place a fall mat at the bedside and did not realize she should have one. NA#2 stated he would review the care plan and get a fall mat as needed. An interview was conducted with Nurse #1 on 9/27/2023 at 3:13 p.m. and she stated she had been employed at the facility for approximately 6 months. She added Resident #67 was on her assignment regularly. She revealed she was not familiar with the Resident's plan of care and did not recall seeing a fall mat placed beside the bed. She stated Resident #67 had not had a scoop mattress during her employment. An interview was conducted with the Director of	F 656	planning accuracy on 9/29/23. " 100% clinical staff educated on process of the developing and implementation of Care Plans to include location of each resident Care Plan at the nurses station and maintained electronically by 10/18/23 by MDS Coordinator or Designee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained " As a monitoring tool, IDT will discuss resident falls daily during morning clinical meeting, with resident, date of fall, intervention and an individualized fall prevention care plan implemented on 10/17/23. " 100% audit by Director of Nursing Services or Designee will be conducted during the weekly falls meeting x 4 weeks, monthly x 4 weeks, monthly x 3 months and quarterly thereafter to monitor residents at risk for falls, intervention and implementation of comprehensive fall prevention care plan. " Audit Compliance will be discussed weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. " The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change	

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F 656	Continued From page 12 Nursing on 9/17/2023 at 3:20 p.m. and she observed the room for Resident #67. She revealed the Resident did not have a fall mat and did not have a scoop mattress. She stated the two interventions were on the care plan and should be in use. She felt the issue occurred when a room change had to occur last December of 2022 and then the Resident was moved back to the current location after room renovations were completed, in March 2023. She added, at that time, the intervention items must have been misplaced and this was not picked up on during regular Administrative rounds.	F 656	to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		10/26/23

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F 755	Continued From page 13 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the staff and consultant pharmacist, and record reviews, the facility failed to acquire a medication (a combination calcium and vitamin D supplement) ordered for administration resulting in multiple doses of the prescribed medication being missed for 1 of 5 residents (Resident #61) observed for medication administration. The findings included: Resident #61 was admitted to the facility on 7/26/23. Her cumulative diagnoses included diabetes and heart failure. On 9/27/23 at 8:15 AM, Medication (Med) Aide #2 was observed as she prepared and administered 11 oral medications to Resident #61. At that time, the med aide reported this resident's calcium and vitamin D combination tablet was not available on the med cart for administration because it had not been delivered by the pharmacy. A follow-up interview was conducted on 9/27/23 at 11:28 AM with Med Aide #2. During the interview, the med aide confirmed Resident #61's calcium / vitamin D tablets had been previously supplied by the pharmacy. When the process of	F 755	HLR □ Survey 2023 □ F 755 Pharmacy Services □ failed to acquire medications " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Southern Pharmacy Services was contacted on 9/27/23 by DNS and requested to send the ordered Calcium with Vitamin D for Resident 61. The medication was delivered to the facility on 9/28/23 and has remained available for administration. " How will the facility identify other residents having the potential to be affected by the same deficient practice? 100% audit of all medication was completed on 10/18/23 by Director of Clinical Operations. For any medication that was not available for administration: Pharmacy was contacted to obtain medication, MD was notified of missed doses and MD order obtained as needed. As of 10/18/23 any missing medications identified as unavailable will be considered a medication error and that process followed.	

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F 755	Continued From page 14 acquiring medications from the pharmacy was discussed, Med Aide #2 reported the calcium / vitamin D had been ordered from the pharmacy but had not come in. Med Aide #2 reported she did not know why it hadn't been delivered by the pharmacy. A review of Resident #61's electronic medical record (EMR) included her current physician's orders and revealed an active medication order (dated 4/12/23) was written for 315 milligrams (mg) calcium with 250 International Units (IU) vitamin D3 to be given as one tablet by mouth every day. This medication was not administered to Resident #61 as ordered on 9/27/23. A review of the documentation on Resident #61's September 2023 Medication Administration Record (MAR) revealed the resident did not receive the calcium / vitamin D tablet as ordered on 17 of 26 days during the month. The MAR indicated a dose of the calcium / vitamin D supplement was previously missed on each of the following dates: 9/1/23, 9/7/23, 9/8/23, 9/9/23, 9/11/23 - 9/18/23, 9/20/23 - 9/22/23, 9/25/23 and 9/26/23. Seventeen (17) notations were made within the electronic MAR notes which indicated the medication was unavailable and had not been delivered by the pharmacy. An interview was conducted on 9/27/23 at 3:27 PM with Nurse #1. Nurse #1 was identified as the hall nurse assigned to care for Resident #61. During the interview, the nurse reported she was unaware Resident #61's calcium and vitamin D supplement was not available because she typically did not work on that medication cart (the 200 Hall Med Aide's Med Cart). When asked what the process was for ordering refills of	F 755	" What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 100% of Nurses and Medication Aides were educated by 10/18/23 regarding obtaining medication by DNS or Designee. Education included: Contacting pharmacy to order medication, Calling medication into the back up pharmacy, checking the Neyxs for medication, notifying MD for any delay in administration and obtaining orders as needed. Southern Pharmacy was instructed to send all over the counter medication to the facility on 9/28/23 by Director of Clinical Operations Step by step Guide for unavailable medications will be laminated and placed at each nurse□s desk and the front of each medication count book by 10/18/23 by DNS or Designee " How does the facility plan to monitor its performance to make sure that solutions are sustained? MARs will be audited for any medication that was held due to not available for administration starting the week of 10/22/23 by DNS or designee. 100% x4 weeks, 50% x4 weeks and 25% x4 weeks or until substantial compliance achieved. The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3	

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F 755	Continued From page 15 medications from the pharmacy, Nurse #1 reported she could call the pharmacy to check on an order to see if it was already ordered and scheduled for delivery. An interview was conducted on 9/27/23 at 4:07 PM with the facility's consultant pharmacist. During the interview, the pharmacist was asked what the process was for ordering refill medications from the dispensing pharmacy. The pharmacist reported that staff should typically be requesting medication refills electronically. If that didn't work for some reason, staff could manually fax a refill request to the pharmacy. A follow-up interview was conducted on 9/28/23 at 9:25 AM with the consultant pharmacist. The pharmacist reported that Resident #61's calcium and vitamin D supplement had been previously dispensed by the pharmacy on 4/22/23, 5/19/23, 6/29/23 and 7/28/23. She stated the dispensing pharmacy reported they had notified the facility this supplement was available as an over-the-counter (OTC) house stock. The pharmacist indicated the failure to have Resident #61's calcium / vitamin D available for administration appeared to be a miscommunication between the facility and dispensing pharmacy as to which OTC products would be supplied by the pharmacy and which ones would be obtained by the facility as house stock. An interview was conducted on 9/28/23 at 10:02 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the medication administration observations were discussed. The DON reported she was made aware that Resident #61's calcium and vitamin D	F 755	months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	

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F 755	Continued From page 16 supplement had not been available for administration. She stated that since the med administration observation, the medication was delivered by the pharmacy and the resident received a dose as ordered on 9/28/23.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and the consultant pharmacist, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6% for 2 of 5 residents (Resident #72 and Resident #61) observed during the medication administration observation. The findings included: 1. Resident #72 was admitted to the facility on 7/26/23. His cumulative diagnoses included diabetes. On 9/27/23 at 11:30 AM, Nurse #1 was observed as she checked Resident #72's blood glucose (sugar) with the result noted to be 337 milligram (mg) / deciliter (dl). The nurse was then observed as she returned to the medication cart and prepared to administer Novolog insulin in accordance with his sliding scale insulin orders (where the dose of insulin administered would be	F 759	HLR □ Survey 2023 □ F 759 Free From Medication Error " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident 72□s Blood glucose was rechecked on 9/27/23 @ 1:55pm with result of 282. MD was notified of medication error on 9/27/23 by DNS, no new orders received. Resident was monitored for S/S of hypoglycemia, no adverse effects noted by DNS. Southern Pharmacy Services was contacted on 9/27/23 by DNS and requested to send the ordered Calcium with Vitamin D for Resident 61. The medication was delivered to the facility on 9/28/23 and has remained available for administration.	10/26/23

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F 759	Continued From page 17 dependent on the resident's current blood glucose level). Based on Resident #72's blood glucose result, Nurse #1 reported she needed to administer 9 units of Novolog insulin to the resident. The nurse was observed as she primed the insulin pen. Priming an insulin pen before each injection is recommended by the manufacturer to remove air from the insulin cartridge and needle; priming the pen ensures a full dose is administered. After the insulin pen was primed, Nurse #1 dialed the pen to indicate a dose of 9 units of Novolog insulin would be administered to the resident. Nurse #1 was observed as she injected the 9 units of insulin subcutaneously (under the skin) to Resident #72 on 9/27/23 at 11:37 AM. A review of the resident's electronic medical record (EMR) included physician orders dated 8/16/23 for insulin coverage scheduled at 11:30 AM daily. The order indicated Novolog insulin was to be injected subcutaneously according to the following sliding scale: If the resident's blood glucose (BG) = 70 - 120, cover with 0 units of insulin; If BG = 121 - 150, administer 1 unit of insulin; If BG = 151 - 200, administer 2 units of insulin; If BG = 201 - 250, administer 3 units of insulin; If BG = 251 - 300, administer 5 units of insulin; If BG = 301 - 350, administer 7 units of insulin; If BG = 351 - 400, administer 9 units of insulin; If BG is greater than 400, call Medical Doctor (MD). Based on Resident #72's current sliding scale insulin orders, 7 units of Novolog insulin should be administered for a BG of 337 mg/dl.	F 759	" How will the facility identify other residents having the potential to be affected by the same deficient practice? 100% of resident received insulin was audited for S/S of hypoglycemia on 10/18/23 by Director of Clinical or designee. And identified issues were communicated to the MD. Orders obtained as needed. 100% audit of all medication was completed on 10/18/23 by Director of Clinical. For any medication that was not available for administration: Pharmacy was contacted to obtain medication, MD was notified of missed doses and MD order obtained as needed. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 100% of nurses were educated by 9/28/23 regarding priming insulin pens, to include return demonstration by DNS or designee. Education will be added to new nurse orientation. Multidose Injection Competency will be completed in orientation for new nurses and yearly for all nurses by SDS or designee. 100% of Nurses and Medication Aides were educated by 10/18/23 regarding obtaining medication by DNS or designee. Education included: Contacting pharmacy to order medication, Calling medication into the back up pharmacy, checking the Neyxs for medication, notifying MD for any delay in administration and obtaining orders as needed. Education will be	

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F 759	Continued From page 18 An interview was conducted with Nurse #1 on 9/27/23 at 1:07 PM. During the interview, the nurse was asked about the discrepancy of the insulin dose administered to Resident #72 (9 units) versus 7 units of sliding scale insulin ordered for a blood glucose of 337. The nurse reported she was taught to always "double prime" an insulin pen. When asked for further clarification, the nurse stated she always primed an insulin pen with 2 units of insulin. After the initial priming, she would then dial the insulin pen to add 2 more units of insulin to the actual dosage ordered for administration. She reported this would "double prime" the pen. Upon inquiry, Nurse #1 acknowledged she "always" added 2 units to the prescribed insulin dose administered to a resident. An interview was conducted on 9/27/23 at 4:07 PM with the facility's consultant pharmacist. During the interview, the pharmacist was asked what her thoughts were with regards to the "double priming" of an insulin pen. The pharmacist responded by stating the initial priming of the pen was done to ensure accuracy of the insulin dose administered to the resident. Additional insulin should not be added to the insulin dose administered to a resident. An interview was conducted on 9/28/23 at 10:02 AM with the facility's Director of Nursing (DON). During the interview, the DON reported education had already been provided to Nurse #1 on correct insulin dosing and administration with a return demonstration. 2. Resident #61 was admitted to the facility on 7/26/23. Her cumulative diagnoses included diabetes and heart failure.	F 759	added to new nurse orientation. Southern Pharmacy was instructed to send all over the counter medication to the facility on 9/28/23 by Director of Clinical Operations. Step by step Guide for unavailable medications will be laminated and placed at each nurse□s desk and the front of each medication count book by 10/18/23 by DNS. " How does the facility plan to monitor its performance to make sure that solutions are sustained? One nurse for each shift will be observed administering insulin injection by DNS or Designee, starting the week of 10/22/23, 3 times weekly x 4 weeks, 2x weekly x 4 weeks and weekly x 4 weeks or until substantial compliance achieved. Multi dose injection competency will be used for observations. MARs will be audited for any medication that was held due to not available for administration starting the week of 10/22/23. 100% x4 weeks, 50% x4 weeks and 25% x4 weeks or until substantial compliance achieved. The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in	

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F 759	Continued From page 19 On 9/27/23 at 8:15 AM, Medication (Med) Aide #2 was observed as she prepared and administered 11 oral medications to Resident #61. At that time, the med aide reported this resident's calcium and vitamin D combination tablet was not available on the med cart for administration because it had not been delivered by the pharmacy. A review of Resident #61's EMR included her current physician's orders and revealed an active medication order (dated 4/12/23) was written for 315 milligrams (mg) calcium with 250 International Units (IU) vitamin D3 (the natural form of vitamin D produced by the body from sunlight) to be given as one tablet by mouth every day. This medication was not administered to Resident #61 as ordered on 9/27/23. An interview was conducted on 9/28/23 at 10:02 AM with the facility's Director of Nursing (DON). During the interview, results of the medication administration observations were discussed. The DON reported she had been made aware that Resident #61's calcium and vitamin D supplement was not available for administration. She stated this medication has since come in from the pharmacy and the resident received a dose of it on 9/28/23.	F 759	servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		10/26/23

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F 761	Continued From page 20 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and the consultant pharmacist, and record reviews, the facility failed to: 1) Label medications with the minimum information required, including the first and last name of the resident on 3 of 3 medication (med) carts observed (the 300 Hall Nurse's Med Cart, the 100 Hall Nurse's Med Cart, and the 300 Hall Med Aide's Med Cart); 2) Store medications in accordance with the manufacturer's storage instructions on 2 of 3 med carts (300 Hall Nurse's Med Cart and the 300 Hall Med Aide Med Cart); and 3) Discard an expired medication on 1 of 3 med carts observed (the 300 Hall Med Aide's Med Cart). The findings included: 1-a. An observation was conducted on 9/26/23 at	F 761	HLR □ Survey 2023 □ F 761 Store of Drugs and Biologicals " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by this deficient practice " How will the facility identify other residents having the potential to be affected by the same deficient practice? All medications carts were audited by 10/18/23 by DNS or designee to ensure all medication were labeled with resident□s first and last name. Any identified issues were corrected.	

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F 761	Continued From page 21 3:58 PM of the 300 Hall Nurse's medication (med) cart in the presence of Nurse #3. The observation revealed the following medications stored on the med cart failed to be labeled with the minimum information required: --An opened, manufacturer's bottle of 0.4 milligrams (mg) nitroglycerin tablets (a medication used to treat angina or chest pain) was stored on the med cart. A hand-written notation on the top of the cap only read, "305B 7/26." The bottle of tablets did not include the minimum required information, including the resident's first and last name. --One Lantus Solostar insulin pen with a handwritten notation on the pen read, "9/24" and "[a last name only]." The medication label did not include the minimum information required, including both the first and last name of the resident. 1-b. An observation was conducted on 9/26/23 at 3:58 PM of the 300 Hall Nurse's med cart in the presence of Nurse #3. The observation revealed two vials of 0.5 mg/3 mg per 3 milliliters (ml) of ipratropium/albuterol inhalation solution (an inhaled medication delivered via a nebulizer to treat asthma or chronic obstructive lung disease) dispensed for Resident #74 were stored outside of the manufacturer's foil pouch. There was no notation of when the vials had been removed from the foil pouch. Storage Conditions printed on the foil pouches read: "Protect from light. Unit dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within two weeks." An interview was conducted with Nurse #3 on 9/26/23 at 4:15 PM. During the interview, the	F 761	All nebulizer treatments were audited by 10/18/23 by DNS or designee for stored in the foil package and labeled with date opened. Any treatments found to be stored outside the foil package or not labeled were discarded. All medication carts were audited by 10/18/23 by DNS or designee for any eye gtts that indicated store upright in the manufacture's storage instructions. Any eye gtts found to be stored not upright were discarded All suppositories were audited for out of date by 10/18/23 by DNS or designee. Any suppository that was out of date was discarded. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 100% education of nurses regarding: Labeling Medication, to include first and last name and open date of nebulizer packet, Storing eye gtts according to manufacturer recommendations and storing nebulizer treatments in the foil packet will be completed by 10/18/23. Education will be added to the new nurse orientation and conducted by SDC. Plastic storage bags with labels will be stored beside the Nexys by DNS or designee to allow for labeling of small items, such as nitroglycerin tablets by 10/18/23. Southern Pharmacy Services will label any eye gtts with manufacturer recommendations to store upright by 10/18/23.	

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F 761	Continued From page 22 findings of the med cart observation were discussed. The nurse confirmed the vials of inhalation solution should have been dated as to when they were removed from the pouch. Upon review of the insulin pen, the nurse stated the pen may have been obtained from the facility's emergency medication stock. 2-a. An observation was conducted on 9/26/23 at 4:22 PM of the 100 Hall Nurse's medication cart in the presence of Nurse #4. The observation revealed the following medications stored on the med cart failed to be labeled with the minimum information required: --One Lantus Solostar insulin pen with a handwritten notation on the pen read, "[an initial for the first name and a last name]." A pharmacy auxiliary sticker placed on the pen indicated the "Date opened" was 9/19/23. The medication label did not include the minimum information required, including both the first and last name of the resident. --One Humalog insulin Kwikpen with a handwritten notation on the pen read, "[last name only]." A pharmacy auxiliary sticker placed on the pen indicated the "Date opened" was 9/21/23. The medication label did not include the minimum information required, including both the first and last name of the resident. --One Basaglar insulin pen with a handwritten notation on the pen read, "9/12/23" and "[a last name only]." The medication label did not include the minimum information required, including both the first and last name of the resident. An interview was conducted with Nurse #4 on 9/26/23 at 4:30 PM. Upon review of the insulin pens identified without the minimum required labeling information, the nurse reported she	F 761	Night shift nurses will audit insulin pens weekly to ensure each pen is labeled with resident□s first and last name and date opened, starting the week of 10/22/23. " How does the facility plan to monitor its performance to make sure that solutions are sustained? Medication carts will be audited by DNS or designee, starting the week of 10/22/23, to ensure medication are correctly labeled, to include resident□s first, last name and date opened as indicated, and medication are correctly stored, to include eye gtts stored upright according to manufacturer recommendations and neb treatments in foil packet. 100% 4 weeks, 50% x 4 weeks and 25% x 4 weeks or until substantial compliance achieved The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	

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thought sometimes the pharmacy delivered multiple insulin pens at a time with only one label provided.

3-a. Accompanied by Med Aide #1, an observation was made on 9/26/23 at 4:33 PM of the 300 Hall Med Aide's medication cart. The observation revealed one packet of 0.8 grams (g) sevelamer carbonate for oral suspension (a phosphate binder) was not labeled with the minimum required information, including the resident's name.

3-b. Accompanied by Med Aide #1, an observation was made on 9/26/23 at 4:33 PM of the 300 Hall Med Aide's medication cart. The observation revealed an opened bottle of neomycin / polymyxin B / dexamethasone 0.1% ophthalmic suspension (a combination antibiotic and corticosteroid eye drop) dispensed for Resident #47 was stored lying on its side in the med cart. Storage instructions on the manufacturer's labeling of the bottle read in part, "Store upright."

3-c. Accompanied by Med Aide #1, an observation was made on 9/26/23 at 4:33 PM of the 300 Hall Med Aide's medication cart. The observation revealed an opened bottle of 1% prednisolone ophthalmic suspension (a steroid eye drop medication) dispensed for Resident #74 was stored lying on its side in the medication cart. The manufacturer's storage instructions printed on the label of the eye drops provided instructions to store the bottle in an upright position.

3-d. Accompanied by Med Aide #1, an observation was made on 9/26/23 at 4:33 PM of the 300 Hall Med Aide's medication cart. The

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observation revealed an opened manufacturer's box of Dulcolax suppositories (a stimulant laxative) containing 6 suppositories and labeled for Resident #74 was stored on the med cart. The suppositories had a manufacturer's expiration date of June 2023 printed on its label.

An interview was conducted with Med Aide #1 on 9/26/23 at 4:33 PM as the concerns regarding the med cart observations were identified. At that time, Med Aide #1 confirmed the manufacturer's labeling on the eye drop bottles indicated they should be stored in the upright position. She also confirmed the suppositories were past their expiration date.

An interview was conducted on 9/27/23 at 4:07 PM with the facility's consultant pharmacist. During the interview, an inquiry was made as to what information she would expect to be included on the label of a medication dispensed from the pharmacy. The pharmacist reported that she would certainly expect the full name of the resident that the medication belonged to be on the medication. During a follow-up interview conducted with the pharmacist on 9/28/23 at 9:25 AM, the pharmacist reported only one insulin pen had been pulled from the emergency drug kit for resident use within the last 3 months. She stated that upon review of the extra insulin pens stored in the med room refrigerator, all pens were being sent out from the pharmacy with a "mini-sticker" which included all of the minimum required information. It was not known why the mini-sticker labels were missing from several insulin pens stored on the med carts.

An interview was conducted on 9/27/23 at 4:53 PM with the facility's Director of Nursing (DON) to

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F 761	Continued From page 25 discuss the findings of the medication storage observations. During the interview, the DON stated she would expect medications to be stored in accordance with the manufacturer's instructions.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		10/26/23

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§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,

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resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on

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F 867	Continued From page 28 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 7/14/22. This was for 1 deficiency that was cited in the area of Free of Medication Error Rate of 5 Percent or More (F759). The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QA). The findings included: This citation is cross referred to: F759: During the facility's recertification survey on 9/28/23, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.6% for 2 of 5 residents (Resident #72 and Resident #61) observed during the medication administration observation. During the facility's recertification survey of 7/14/22, the facility's medication error rate was greater than 5% as evidenced by 2 medication errors out of 33 opportunities. There were medication errors for 1 of 4 residents during medication pass observations. The medication error rate was 6.06%. The Administrator was interviewed on 9/28/23 at	F 867	F867: QAPI/QAA Improvement Activities " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. " How will the facility identify other residents having the potential to be affected by the same deficient practice? On 10/19/23, 100% audit of all closed and open QA/QAPI initiatives was completed by QA committee to ensure substantial compliance. On 10/19/23, any QA/QAPI initiatives that were found to be out of compliance were reopened by the QA Committee. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 10/19/23, QA/QAPI team initiated an additional process review of all open initiatives to reflect confirmation of compliance by Administrator On 10/19/23, QA/QAPI team will complete QAPI discussion with outcome and document by Administrator. See above At next QA/QAPI meeting, substantial compliance will be confirmed and documented by Administrator. On 9/28/23 Director of Operations completed 100% education with the QA/QAPI Committee on the requirements of the quality assurance program.	

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F 867	Continued From page 29 2:40 pm. He stated that the QA members were made up of Administrator, the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, and Housekeeping Director. The Nurse Practitioner and the Medical Director were always invited to attend. He also stated that the QA committee usually meets quarterly but they have met monthly this year due to new staff. He also added that the facility has to utilize a lot of agency staff since Covid began and they have recently been able to decrease the amount of agency staff needed. He stated the facility nursing staff meet to discuss this issue and investigate new ways to achieve compliance.	F 867	" How does the facility plan to monitor its performance to make sure that solutions are sustained? On 10/19/23, QA/QAPI team will discuss the updated initiatives implemented and document the completion by Administrator. See above On 10/19/23, Administrator will schedule QA/QAPI meetings. QA/QAPI will be completed quarterly times quarterly times 4 quarters and documented by Administrator. See above.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		10/26/23

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conducted according to §483.70(e) and following accepted national standards;

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

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 31 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility staff failed to clean and disinfect a blood glucose meter (glucometer) dedicated for individual-resident use in a manner that would protect against the cross-contamination from contact with other meters or equipment. This was observed for 2 out of 8 sample residents (Residents #64 and #17) who were observed to have a blood glucose (sugar) check. The findings included: A review of the facility policy entitled "Glucometer Disinfection" (Date Implemented: January 2018; Date Reviewed / Revised: December 2019) included the following "Policy Explanation and Compliance Guidelines" related to the disinfection of glucometers, in part: Policy Explanation and Compliance Guidelines: "1. The facility will ensure blood glucometers will be cleaned, disinfected, and air-dried after each use and according to manufacturer's instructions for multi-resident use.... 2. The glucometers should be disinfected with a wipe pre-saturated with an EPA [Environmental Protection Agency] registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 3. Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether	F 880	HLR □ Survey 2023 □ F 880 Cleaning Glucometer " How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No resident was affected by this deficient practice " How will the facility identify other residents having the potential to be affected by the same deficient practice? 100% of resident that receive finger stick blood glucose were assessed for infection related to finger sticks on 10/18/23 by DNS or designee. Any s/s of infection were communicated with the MD and orders implemented as needed. " What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? 100% education of nursing staff by Director of Clinical Operations or designee, regarding cleaning of glucometers, to include wrapping the meter in the wipe for a minimum of 2 minutes to ensure wet time according to manufacturer guidelines by 10/18/23. Education will be added to new nurse orientation.	

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F 880	Continued From page 32 they are intended for single resident or multiple resident use. 4. Procedure [designated with the letters a. through n.] ... i. Retrieve (2) disinfectant wipes from container. j. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. k. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions...." The manufacturer's "Guidelines for Cleaning and Disinfecting the [Brand Name of Meter]" used at the facility were also reviewed. The "Cleaning and Disinfecting Procedures" read, in part: Step 6 (of 7) "Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. Do not wrap the meter in a wipe." A review of the manufacturer instructions for the disinfectant wipes used to disinfect individual-resident glucometers at the facility included read in part, "Allow treated surface to remain wet for two (2) minutes. Let air dry." The manufacturer of the disinfectant wipes provided additional clarification regarding the product's wet contact time under the topic of "Most Frequently Asked Questions." The response read, "The contact time listed on the product label is the total amount of time that it takes to inactivate all of the microorganisms listed on the product label. This time is typically referred to in minutes, and should be communicated to staff members that are utilizing the disinfectant. In certain geographies	F 880	100% education of nursing staff to place a barrier before placing the glucometer on a resident table will be completed by 10/18/23 by DNS or designee. Education will be added to new nurse orientation. Guide for cleaning glucometer will be laminated and posted at each nurse□s desk by 10/18/23. " How does the facility plan to monitor its performance to make sure that solutions are sustained? One nurse from each shift will be observed by DNS or designee cleaning the glucometer and for placing a barrier on resident□s table in room starting the week of 10/22/23, 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 4 weeks or until substantial compliance achieved. The ED/designee will bring results of audit to the facility monthly QAPI meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 09/28/2023

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and also in settings where temperature, relative humidity, and air changes may vary, it is possible that the surface may not remain visibly wet for the designated contact time. Current EPA [Environmental Protection Agency] guidance requires that the treated environmental surface or equipment remains wet for the contact time stated on product label. Additional wipes may be needed in order to comply with the EPA guidance, however the overall contact time does not change ..."

An observation was conducted of Nurse #2 on 9/27/23 at 11:41 AM as she prepared to do a blood glucose check for Resident #64. The nurse pulled Resident #64's glucometer stored in the manufacturer's box from the medication (med) cart. Both the meter and the box were labeled with Resident #64's name. The nurse removed the glucometer from the box and collected the supplies needed for a blood glucose check (test strips, two alcohol prep pads, a lancet, and gloves). She wiped the glucometer with an alcohol wipe for 3 seconds, placed the meter directly on top of the med cart, then inserted a test strip. The nurse picked up the glucometer with supplies and entered the resident's room on 9/27/23 at 11:45 AM. After the blood glucose check, the nurse exited the room at 11:47 AM and returned to the med cart. Nurse #2 was observed as she wiped the glucometer with a disinfectant wipe for two (2) seconds, then immediately returned the meter to the box before storing it in the med cart. The meter did not appear to be visibly wet when placed in the box for storage.

On 9/27/23 at 11:53 AM, Nurse #2 was observed as she removed a new glucometer from its box and prepared to do a blood glucose check for

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Resident #17. The nurse placed the meter on top of her closed laptop computer, donned gloves, and used an alcohol wipe to wipe the glucometer for 2-3 seconds prior to using it. The nurse discarded her gloves and performed hand hygiene. Nurse #2 then gowned and gloved at the entrance of Resident #17's room (the resident was on Enhanced Contact Precautions). On 9/27/23 at 11:57 AM, the nurse placed the glucometer on the resident's bedside tray table. She used the meter to test Resident #17's blood glucose before placing the meter back on the bedside tray table. Nurse #2 was observed as she slid the glucometer across the table's surface, then picked it up and returned to the med cart. On 9/27/23 at 12:00 PM, the nurse used an alcohol wipe to wipe the glucometer for 2-3 seconds before returning it to the box for storage in the med cart. When finished, the nurse was observed to pull a disinfectant wipe from the container placed on top of the med cart to wipe off the top of the med cart.

An interview was conducted on 9/28/23 at 9:03 AM with Nurse #2. During the interview, the concerns regarding the glucometer disinfection observed were discussed. The nurse reported either an alcohol wipe or disinfectant wipe could be used to disinfect a glucometer. Nurse #2 stated she typically used a disinfectant wipe to disinfect the residents' glucometers at the beginning and end of each day.

An interview was conducted on 9/28/23 at 10:02 AM with the facility's Director of Nursing (DON). During the interview, the DON reported the facility's nurses were educated to disinfect the individual-resident use meters after each use in accordance with the manufacturer's directions.

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She stated the disinfectant used at the facility required a 2-minute wet contact time.

On 9/28/23 at 11:35 AM, a follow-up interview was conducted with the Directors and the DON. At that time, the Directors confirmed that wiping the glucometer with a disinfectant wipe only kept the meter wet for 50 seconds and would require a meter to be re-wiped after a minute or so to keep the surface wet for recommended contact time indicated by the manufacturer of the disinfectant wipes.

Upon request, an interview was conducted on 9/28/23 at 11:20 AM with the facility's corporate Director of Operations and Director of Clinical Operations. During the interview, the Directors expressed concern regarding possible discrepancies between the glucometer instructions for disinfection (indicating the glucometer should not be wrapped in a wipe) and the disinfectant wipe instructions for disinfecting the machine. At that time, the Directors were informed the observations conducted of glucometer disinfection included use of an alcohol pad or a 2-3 second wipe of glucometers with a disinfectant wipe.