STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW LUMBERTON	1555 WILLIS AVENUE LUMBERTON, NC 28358

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 01/22/24 through 01/25/24. Event ID #L05511. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/22/24 through 01/25/24. Event ID # L05511. 2 of the 7 complaint allegations resulted in deficiency. The following intakes were investigated: NC00211328 NC00207189 NC00210277 NC00210726 The statement of deficiencies was amended on 02/09/24.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner (NP) interviews, the facility failed to provide a physician order for the care of and daily	F 658	1.Immediate action(s) taken for the resident found to have been affected include:	2/13/24

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

Electronically Signed | 02/09/2024

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F 658	Continued From page 1 flush of a cholecystostomy (gallbladder) drainage tube for 1 of 1 resident (Resident #36) reviewed for a drainage tube. Findings included: Resident #36 was readmitted to the facility on 11/27/23 with a diagnosis of acute cholecystitis (gallbladder inflammation caused by gallstones). Review of Resident #36's electronic health record revealed an After Visit Discharge Summary dated 11/27/23 which indicated a discharge diagnosis of acute cholecystitis and stated she had a cholecystostomy tube (a drainage tube placed into the gallbladder) for symptomatic improvement of acute cholecystitis. The discharge instructions indicated to flush the cholecystostomy tube one time per day, keep the tube in place and keep the area clean and dry. Review of Resident #36's physician orders revealed no order dated 11/27/23 to flush the cholecystostomy tube or any instructions regarding the care or maintenance of the tube. Review of Resident #36's 12/31/23 quarterly Minimum Data Set (MDS) assessment indicated resident was cognitively intact, had an indwelling catheter and an ostomy. Review of Resident #36's January 2024 electronic Treatment Administration Record (TAR) revealed a 1/4/24 entry to apply a dry dressing around the drainage tube on the abdomen every three days. Review of Resident #36's 1/24/24 care plan indicated the resident required the use of a	F 658	Clarification care, flush, and monitoring orders were immediately added to the electronic health record. SDC initiated immediate education to all nurses and CNAs on biliary drainage tube care/monitoring. Biliary drainage tube orders were immediately added to the resident□s care plan. 2.Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing conducted an audit on 1/24/24 with no other residents noted to have a biliary drainage tube. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: The SDC completed in-servicing to all nurses and CNAs on caring for/monitoring biliary drainage tubes. Completed by 02/13/2024. The SDC will be responsible for in-servicing all new nurses and CNAs during their orientation on proper care/monitoring of biliary drainage tubes. New admission assessments will be reviewed the following morning in clinical meeting to identify new residents with biliary drainage tubes in place. 4.How the corrective action(s) will be monitored to ensure the practice will not recur: The Staff Development Coordinator will provide education regarding	

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F 658	Continued From page 2 colostomy related to history of rectal cancer and a urinary catheter related to urinary obstruction. The cholecystostomy tube was not included in the care plan. An interview was conducted with Resident #36 on 1/24/24 at 11:45 AM. Resident #36 revealed she had nausea all the time related to her gall bladder. Resident #36 stated she had the gallbladder drainage tube in place since November 2023 due to gall stones. Resident #36 stated sometimes the nursing staff checked the drainage tube for her gallbladder. Interview with Nurse #1 on 1/24/24 at 11:50 AM revealed Resident #36 had a drainage tube, but she forgot what they called the type of drainage tube or what it was for. Nurse #1 stated there should be a physician order for the care of the drainage tube, but she did not see any orders in Resident #36's electronic health record. Interview with Nurse #3 on 1/24/24 at 3:50 PM revealed Resident #36 had a drainage tube, but she was not sure what type or what it was for. Nurse #3 stated she squeezed the device and drained it every now and then. Nurse #3 stated she did not recall seeing any orders regarding the drainage tube, did not know of anything to observe for or any special care required. Nurse #3 indicated there was no order in the electronic health record to flush Resident #36's cholecystostomy tube. Interview with the Nurse Practitioner (NP) on 1/25/24 at 10:30 AM revealed she expected the physician order from the after-visit summary discharge summary report dated 11/27/23 to flush the cholecystostomy tube one time per day to	F 658	care/monitoring of biliary drainage tubes will be ongoing at hire, annually and PRN for nurses and CNAs. Any admission/readmission will be reviewed weekly x 12 weeks by the Director of Nursing in morning clinical meeting to identify the presence of a biliary drainage tube. Any identified residents with a biliary drainage tube will be assessed for complete orders and care planned accordingly. Additionally, the competency of assigned nurses and CNAs will be evaluated. The Director of Nursing will present findings of the clinical meetings to the QAPI committee twice monthly for 3 months to determine if additional training is needed.	

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F 658	Continued From page 3 have been transcribed and followed. The NP stated the cholecystostomy tube site should be monitored daily for infection, the drainage should be monitored and orders for this should have been included in Resident #36's electronic health record. Interview with the Director of Nursing (DON) on 1/25/24 at 1:45 PM revealed there should have been care instructions in Resident #36's electronic health record regarding the cholecystostomy tube. The DON further indicated the order to flush the tube daily should have been transcribed into the electronic Treatment Administration Record (TAR). Interview with the Administrator on 1/25/24 at 1:50 PM revealed the orders for care of the cholecystostomy tube and to flush the tube should have been in place.	F 658		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies	F 726		2/13/24

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F 726	Continued From page 4 and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner (NP) interviews, the facility failed to provide education to the nursing staff to deliver care for a cholecystostomy (gallbladder)drainage tube for 1 of 1 resident (Resident #36) reviewed for a drainage tube. Findings included: Resident #36 was readmitted to the facility on 11/27/23 with a diagnosis of acute cholecystitis (gallbladder inflammation caused by gallstones). Review of Resident #36's electronic health record revealed an After Visit Discharge Summary dated 11/27/23 which indicated a discharge diagnosis of acute cholecystitis and stated she had a cholecystostomy tube (a drainage tube placed into the gallbladder) for symptomatic improvement of acute cholecystitis. The discharge instructions indicated to flush the cholecystostomy tube one time per day, keep the	F 726	1. Immediate action(s) taken for the resident(s) found to have been affected include: Clarification care, flush, and monitoring orders were immediately added to the electronic health record. SDC initiated immediate education to all nurses and CNAs on biliary drainage tube care/monitoring. 2. Identification of other residents having the potential to be affected was accomplished by: An audit was conducted by the Director of Nursing on 1/24/24 with no other residents have a biliary drainage tube. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The SDC completed in-servicing to all	

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F 726	Continued From page 5 tube in place and keep the area clean and dry. Review of Resident #36's 12/31/23 quarterly Minimum Data Set (MDS) assessment indicated resident was cognitively intact, had an indwelling catheter and an ostomy. Review of Resident #36's January 2024 electronic Treatment Administration Record (TAR) revealed a 1/4/24 entry to apply a dry dressing around the drainage tube on abdomen every three days. Review of Resident #36's 1/24/24 care plan indicated the resident required the use of a colostomy related to history of rectal cancer and a urinary catheter related to urinary obstruction. The cholecystostomy tube was not included in the care plan. Interview with Resident #36 on 1/24/24 at 11:45 AM revealed she had nausea all the time related to her gall bladder. Resident #36 stated the nursing staff checked the drainage tube for her gallbladder sometimes. Resident #36 stated she told the staff how to care for the drainage tube, including using caution with it so it did not get caught on something and to empty it regularly. Interview with Nurse #1 on 1/24/24 at 11:50 AM revealed Resident #36 had a catheter, colostomy, and a drainage tube. Nurse #1 stated she forgot what they called the type of drainage tube Resident #36 had but she thought it had something to do with her bowels. Nurse #1 stated the drainage tube had a button on the side to drain it and sometimes she pressed the button. Interview with the Staff Development Coordinator	F 726	nurses and CNAs on caring for/monitoring biliary drainage tubes. Completed by 02/13/2024. The SDC will be responsible for in servicing all new nurses and CNAs during their orientation on proper care/monitoring of biliary drainage tubes. New admission assessments will be reviewed the following morning in clinical meeting to identify new residents with biliary drainage tubes in place. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Education regarding care/monitoring of biliary drainage tubes will be ongoing at hire, annually and PRN for nurses and CNAs. Beginning the week of 2/12/24, an interview will be conducted with 3 random nursing department employees by the Staff Development Coordinator per week for 12 weeks to discuss any areas of their job they feel could benefit from further education. Education will be provided on any identified areas. The Director of Nursing will present the findings of the audits to the QAPI committee twice monthly for 3 months to determine if additional audit/training is required.	

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F 726	Continued From page 6	F 726		

(SDC) on 1/24/24 at 2:40 PM revealed she normally provided in service education with the staff when a resident was admitted or readmitted with a procedure, device, or equipment that they were not familiar with. The SDC stated a cholecystostomy tube was not something that was seen in the facility often and required special training and education. The SDC stated she was not familiar with what type of drainage tube Resident #36 had and she had not provided education to the staff about it. The SDC stated she did not know why she had not provided education to the staff regarding Resident #36's cholecystostomy tube. The SDC stated she did not know much about a cholecystostomy tube but stated there should be a physician order for the care of the tube and staff should be educated about it.

Interview with Nurse #3 on 1/24/24 at 3:50 PM revealed Resident #36 had a drainage tube, but she was not sure what type or what it was for. Nurse #3 stated she squeezed the device and drained it every now and then. Nurse #3 stated she had not received any training regarding Resident #36's drainage tube. Nurse #3 stated she did not know of anything to observe for or any special care required with the drainage tube.

Interview with the Nurse Practitioner (NP) on 1/25/24 at 10:30 AM revealed she expected the nurses would be informed of the type of drainage tube and the risks involved. The NP stated the cholecystostomy tube site should be monitored daily for infection and the drainage should be monitored. The NP stated with any tube there was a risk of obstruction, infection, and dislodgement. The NP stated if a cholecystostomy was dislodged the resident

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F 726	Continued From page 7 would require transport to the hospital for replacement. Interview with Nursing Assistant (NA) #1 on 1/25/24 at 12:25 PM revealed she was familiar with Resident #36's care. NA #1 stated Resident #36 had a Foley catheter, a colostomy, and some other type of tube but she did not know what type of tube it was, had not been instructed regarding any special care or precautions with the tube and had not received in service education regarding it. NA #1 stated the nurse normally took care of Resident #36's drainage tube. NA #1 stated she thought the nurse emptied the drainage tube, but she was not sure. Interview with the Director of Nursing (DON) on 1/25/24 at 1:45 PM revealed there should have been care instructions in Resident #36's electronic health record regarding the cholecystostomy tube. The DON indicated the nurses should have been instructed on how to care for a resident with a cholecystostomy tube. Interview with the Administrator on 1/25/24 at 1:50 PM revealed the staff should have been aware of how to care for a resident with a cholecystostomy tube.	F 726		
F 755 SS=D	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	F 755		2/16/24

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F 755	Continued From page 8 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. §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 record review and staff interviews, the facility failed to secure unused narcotic medications for disposition (the process of returning unused medications to the pharmacy) resulting in possible diversion (the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use). This was for 1 of 1 discharged resident (Resident #256) reviewed for pharmacy services. Findings included: Resident #256 was admitted to the facility on	F 755	1. The facility failed to secure unused narcotic medications for disposition resulting in possible diversion of a discharged resident□s medication. The resident missed no doses of medication due to being discharged. The facility initiated an investigation and reported the alleged drug diversion to the appropriate authorities as well as the NC Board of Nursing. An audit was conducted at the time of the investigation by nursing staff to reconcile current controlled substances were accounted for and accurate. The	

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F 755	Continued From page 9 8/7/2023 and she discharged home with her husband on 8/8/2023. The physician's orders for Resident #256 dated 8/7/2023 revealed she was ordered hydrocodone/acetaminophen 7.5-325 mg, give 1 tablet by mouth every 4 hours as needed for pain for 14 days and hydromorphone hydrochloride oral tablet, give 1 mg by mouth every 4 hours as needed for unspecified abdominal pain for 20 days. She was also prescribed fentanyl patch every 72 hours 25 micrograms (mcg)/hour, apply 1 patch transdermal (on the skin) every 72 hours for pain for 30 days and removed per schedule. The Controlled Drug Administration sheet for Resident #256's hydrocodone-acetaminophen 7.5-325 mg dated 8/8/2023 revealed 30 tablets were dispensed to the facility and no tablets were signed out as administered, and no tablets were returned to the pharmacy. An Initial Allegation report revealed the facility became aware of the possible misappropriation of a controlled substance on 8/9/2023 at 5:00 PM and an investigation was initiated. Narcotic sheets and controlled substances were found in a staff member's unlocked desk drawer. Two of the three sheets with matching controlled substances were found in the unlocked desk drawer. The third narcotic count sheet (hydrocodone 7.5-325 mg) did not have accompanying controlled substances. Resident discharged on 8/8/2023. The police were notified on 8/10/2023 at 10:15 AM. The Investigation Report submitted on 8/16/2023 revealed the accused employee was Nurse #8 for an allegation of diversion of Resident #256's	F 755	pharmacist also conducted an audit of all current controlled substances on 8/15/23. No discrepancies were found. 2. All residents with orders for controlled substances have the potential to be affected by this practice. 3. The signature of two nurses will be required at the time unused controlled substances are removed from the medication cart. Two nurses will sign the count sheet as well as the accountability sheet that records the number of count sheets/cards of medications added or removed during the shift. 4. All licensed nurses and medication aides will be educated by the Staff Development Nurse on this process by 2/16/24. 5. Beginning the week of 2/19/24, an audit will be conducted weekly for 12 weeks by the Director of Nursing to review the accountability sheets to ensure licensed personnel are complying with this process. The director of nursing will report findings to the quality assurance performance improvement committee twice monthly for 3 months and based on the findings determine if additional follow up is required. The Director of Nursing is responsible for this Plan of correction with alleged compliance of 2/16/24.	

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F 755	Continued From page 10	F 755		

drugs. Nurse #8 declined a drug screen and resigned from her position effective immediately. The allegation was not substantiated by the facility.

An interview was conducted with the Pharmacist Consultant on 1/24/2024 at 10:06 AM. The Pharmacist stated that all narcotics that are discontinued are supposed to be sent back to the pharmacy for disposal. She further stated that if the resident was discharged the medication should be sent with the resident if their insurance paid for it. The Pharmacist consultant indicated that narcotics were supposed to be kept double locked and should not have been in an unlocked desk drawer. The Pharmacist Consultant stated that she had been the facility consultant since September 2023, and she was unaware of the investigation for diversion. She further stated that during her audits at the facility she had never found any discrepancies.

An interview was conducted with the Staff Development Coordinator (SDC) Nurse on 1/24/2024 at 1:29 PM. The SDC Nurse stated that on 8/9/2023 she was looking for a newly admitted resident's narcotic medication and she was unable to find it. She further stated that she remembered that Resident #256 was taking the same medication (hydromorphone) and she went to see if it was accidentally delivered to the wrong medication cart. The SDC Nurse indicated that when she went to the medication cart on the hall where Resident #256's narcotics were kept, the Controlled Medication Administration sheets and the narcotic medications were not there. She stated that the nurse on the cart told her Nurse #8 (the former Assistant Director of Nursing (ADON)) had already removed Resident #256's

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discontinued narcotic medications from the cart earlier that day. The SDC explained that 3 nurses at the facility had the keys to the discontinued medication cabinet in the Omnicell (automated medication dispensing machine) room and they were the Director of Nursing (DON), the ADON, and herself. She further stated that she had called the pharmacy and the new resident's narcotics had not been delivered to the facility yet. The SDC Nurse indicated that when she looked inside the cabinet, Resident #256's discontinued narcotic medications were not there. The SDC Nurse stated that she immediately informed the DON of the missing narcotic medications, and they began to search the building for them. She indicated that they had gone to Nurse #8's unlocked office on the main hall and found 3 narcotic Controlled Medication Administration sheets with 2 of the corresponding narcotic pill cards in an unlocked drawer. The SDC Nurse stated that Resident #256's hydrocodone 7.5-325mg tablets was the missing medication and the Controlled Medication Administration sheet for the medication indicated there should have been 30 pills. She stated that they had called Nurse #8 to come back to the facility and she did return. The SDC stated that Nurse #8 was unable to produce the missing medication and resigned immediately when asked to take a drug test. She further stated that someone from the pharmacy came to the facility the next day and counted all the narcotics, and no discrepancies were found. The SDC Nurse indicated that the Board of Nursing and the police were notified.

An interview was completed with the current ADON on 1/24/2024 at 11:42 AM. The ADON stated that when a resident's narcotic

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medications were discontinued, they were placed in a locked cabinet in the Omnicell room which was also locked. She further stated that 2 nurses' signatures were required on the return sheet for the discontinued narcotic medications. The ADON indicated that someone from the pharmacy came to the facility monthly to secure the medications and take them back to the pharmacy.

An interview was conducted with the DON and the Administrator on 1/24/2024 at 11:52 AM. The DON stated that on 8/9/2023 the SDC Nurse came to her and explained that she could not find Resident #256's narcotic medications. She further stated the SDC Nurse informed her the narcotic medications had been removed from the cart on the hall by Nurse #8 and they were not in the locked discontinued medication cabinet in the Omnicell room. The DON indicated Nurse #8 had left earlier that day, so they went to search in her unlocked office. She stated that when they searched Nurse #8's desk they found 3 Controlled Medication Administration sheets but only 2 pill cards containing narcotic pills in an unlocked drawer. The DON further stated that the missing medications were 30 of Resident #256's discontinued hydrocodone 7.5 -325 mg tablets. She explained they had called Nurse #8 and asked her to return to the facility and she had returned. The DON stated that when Nurse #8 came back to and they recapped what they had found to her, she initially said she didn't know how the medication had gotten in her desk drawer in her office. She further stated that when Nurse #8 was asked if she would take a drug test that she immediately declined and then resigned effective immediately. The DON indicated that Nurse #8 asked if they were going to report her to the North

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F 755	Continued From page 13 Carolina Board of Nursing. The DON stated they had reported her to the Board of Nursing, and they had called the police. The Administrator stated that she had contacted the Board of Nursing and they had requested further information and signed statements from the other staff involved. The Administrator reported that Nurse #8's nursing license was still active as of 1/24/2024. The Administrator stated a police officer had come to the facility and taken a report, and he had told her an investigator would be assigned to the case. The Administrator indicated the facility had not substantiated the allegation of misappropriation of resident's property against Nurse #8 because she had refused the drug test and she could not be 100% sure. She further stated that she was unsure of what the facility could have done differently to prevent this from happening, because she felt it was an isolated incident. The Administrator indicated the process was still the same as far as how they disposed of discontinued narcotics.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the parameter ordered for administration of a medication used to treat diabetes resulting in 7 doses of insulin Glargine 25 units administered in error for 1 of 1 resident (Resident #47) reviewed for medication error.	F 760	1. The facility failed to follow the parameter ordered for administration of a medication used to treat diabetes resulting in 7 doses of insulin Glargine 25 units being administered for one resident. The resident experienced no adverse effects due to receiving the insulin outside of the parameter order. The medical	2/16/24

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F 760	Continued From page 14 Findings included: Resident #47 was admitted to the facility on 11/24/21 with diagnosis which included in part diabetes and Alzheimer's Dementia. Resident #47's 11/1/23 quarterly Minimum Data Set (MDS) assessment indicated resident had severe cognitive impairment with no behaviors noted. The MDS further indicated Resident #47 received Insulin injections daily during the 7 day look back period and had no changes to the insulin orders. Review of Resident #47's electronic medical record revealed a 5/23/23 physician order for insulin Glargine Solution Pen injector 100 units per milliliter. Inject 25 units subcutaneously one time a day related to diabetes. Hold the Insulin if blood sugar reading less than 175. Review of Resident #47's 8/8/23 care plan revealed a focus of diabetes with history of hypoglycemia and hyperglycemia. The goal indicated Resident #47 would have no complications related to diabetes through the next review date. Interventions indicated diabetes medications as ordered by the doctor and to observe and document for side effects and effectiveness. Review of Resident #47's January 2024 electronic Medication Administration Record (MAR) revealed the following documentation: 1/1/24 resident's blood sugar was recorded as 138 and the scheduled insulin Glargine 25 units was administered by Nurse #1. 1/4/24 blood sugar was 83 and the scheduled	F 760	director was notified on 1/23/24 of this error and gave new orders to discontinue the parameter order and administer the insulin with food. 2. All residents that have orders for insulin were audited for having insulin ordered outside of parameters. No other active residents had orders for parameters with insulin. 3. All licensed nurses received education on closely following physicians orders by 2/9/24. 4. Beginning the week of 2/12/24, an audit will be conducted weekly for 12 weeks by the Assistant Director of Nursing to review the insulin orders and administration of insulin to ensure the parameters, if any, are being followed. 5. The Director of Nursing will report findings to the quality assurance performance improvement committee twice monthly for 3 months and based on the findings, determine if additional follow-up is required. The Director of Nursing is responsible for this plan of Correction with alleged compliance of 2/16/24.	

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insulin Glargine 25 units was administered by Nurse #1 at 7:38 AM.
1/6/24 blood sugar was 120 and the scheduled insulin Glargine 25 units was administered by Nurse #2 at 11:19 AM.
1/8/24 blood sugar was 102 and the scheduled insulin Glargine 25 units was administered by Nurse #1 at 8:21 AM.
1/11/24 blood sugar was 71 and the scheduled insulin Glargine 25 units was administered by Nurse #1 at 8:21 AM.
1/18/24 blood sugar was 80 and the scheduled insulin Glargine 25 units was administered by Nurse #1 at 7:58 AM.
1/23/24 blood sugar was 158 and the scheduled insulin Glargine 25 units was administered by Nurse #1 at 7:55 AM.

Interview on 1/23/24 at 2:40 PM with Nurse #1 revealed a check mark with the initials on the electronic MAR indicated the dose of medication was administered. The January 2024 electronic MAR was reviewed with Nurse #1 who stated she administered Resident #47's insulin on 1/1/24, 1/4/24, 1/8/24, 1/11/24, 1/18/24, and 1/23/24. Nurse #1 stated she had not read the entire order for the insulin and had not seen the parameter to hold the insulin based on the blood sugar reading. Nurse #1 stated she made a mistake giving the medication and she should have been held Resident #47's insulin when it was below the specified blood sugar level.

Attempts made to interview Nurse #2 via phone were unsuccessful.

Interview on 1/23/24 at 3:00 PM with the Director of Nursing (DON) revealed Resident #47's Insulin should have been held according to the

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F 760	Continued From page 16 parameters indicated by the physician and this was a significant medication error. The DON indicated she expected the nurses to read and follow the entire order when they administered medications, especially insulin. The DON stated she would begin education with the nurses immediately. Interview on 1/25/24 at 10:30 AM with the Nurse Practitioner (NP) revealed she expected insulin to be given according to the physician order and the parameter to hold the medication should be followed. The NP stated it was a significant medication error to administer insulin outside of the parameters. The NP stated she was not notified that Resident #47 received doses of insulin outside of the parameter as specified in the physician order. The NP revealed that the administration of insulin Glargine 25 units for a blood sugar less than 175 had the potential for adverse effects but she was not aware of Resident #47 experiencing any of these negative effects.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		2/13/24

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F 761	Continued From page 17 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 record review, observations and staff interviews, the facility failed to date opened multi-dose inhalers and an insulin pen and failed to discard loose pills in the medication cart drawers for 2 of 6 medication carts (300 Hall and 800 Hall carts). Findings included: 1. An observation of the 300 hall medication cart was conducted with Nurse #6 on 1/24/2024 at 9:51 AM. During the observation revealed the following medications were stored on the medication cart: a. An opened box containing an Incruse multidose Ellipta inhaler 62.5 micrograms (mcg) was observed on the cart without an opened date. Incruse Ellipta inhaler is an inhaled medication used to treat chronic obstructive pulmonary disease (COPD). The label on the box revealed it was dispensed from the pharmacy on 9/14/2023 (19 weeks ago) and should be discarded 6 weeks after opening the tray.	F 761	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to date opened multi-dose inhalers and an insulin pen and failed to discard loose pills in the medication cart drawers for 2 of 6 medication carts (300 Hall and 800 Hall carts). The medications and loose pills were removed from the cart at the time they were identified on 1/24/24. Education was immediately initiated for all license nurses and medication aides that medications were to be dated when opened, and that discard dates are added to items that expire within specific time frames after opening. Education also included cleaning loose pills from medication cart drawers at the end of each shift. 2. Identification of other residents having the potential to be affected was accomplished by:	

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F 761	Continued From page 18 b. An opened box containing a Serevent inhaler 50 mcg was observed on the cart without an opened date. Serevent inhaler is an inhaled medication used to treat asthma. The label on the box revealed it was dispensed from the pharmacy on 9/23/2023 (18 weeks ago) and should be discarded 6 weeks after opening the foil pouch. c. Six pills (5 various shaped white pills and 1 round purple pill) were found loose in the bottom of a medication drawer. An interview was conducted with Nurse #6 on 1/24/2024 at 09:51 AM. Nurse #6 stated that it was the nurse on the medication cart's responsibility to date and label the medications. She further stated that she was new to the facility and hadn't realized the inhalers expired 6 weeks after opening. Nurse #6 indicated that pills should not be loose in the medication drawers. An interview was conducted with the Director of Nursing (DON) on 1/24/2024 at 12:46 PM. The DON stated that she expected the inhalers to have an open date on them. She further stated that pills were not supposed to be loose in the medication drawers. The DON indicated that it was the nurse on the medication cart responsibility to check for dates on medications. An interview was conducted with the Administrator on 1/25/2024 at 7:20 AM. The Administrator stated that the facility nurses check their carts frequently and check for expired medications and dates. She further stated that the facility had a Pharmacy Consultant that came frequently and checked for expired medications on the carts and in the medication rooms. The	F 761	All residents have the potential to be affected by this practice. No residents suffered any ill effects related to this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An audit of all medication carts was completed on 1/24/24 by the Assistant Director of Nursing and the Staff Development nurse to check for loose pills and to be sure there were no expired or undated inhalers or insulins. Any identified concerns were immediately corrected. Education was immediately initiated for all licensed nurses and medication aides that medications were to be dated when opened, and that discard dates are added to items that expire within specific time frames after opening. Education also included cleaning loose pills from med cart drawers at the end of each shift. Current licensed nurses and medication aides will receive this education by 2/13/24. New hires will receive education in orientation related to labeling and storage of inhalers and insulin pens, and discarding loose pills from medication carts. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning the week of 2/12/24, all medication carts will be monitored 5x weekly by licensed nurses for 12 weeks.	

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F 761	Continued From page 19 Administrator indicated that since the nurse was new to the facility that had the undated inhalers and loose pills in the drawers, maybe they should increase the education during orientation about medication storage and labeling. 2. An observation of the 800 hall medication cart was conducted with Nurse #7 on 1/24/2024 at 11:04 AM. The observation revealed the following medication was observed on the cart: a. An opened Novolog (insulin aspart) injection flexpen 100 units per milliliter (U/ml) was observed on the cart with no open date on it. Novolog (insulin aspart) injection flexpen is a fast-acting insulin used to treat Type I and Type 2 diabetes. The label on the insulin pen read to discard 28 days after opened. An interview was conducted with Nurse #7 on 1/24/2024 at 11:04 AM. Nurse #7 stated that all the insulin pens were supposed to be dated with an opened date. She further stated that she had checked her cart for dates on the insulin pens and stated that maybe the date had rubbed off the pen. Nurse #7 stated it was her responsibility to check the medication carts for dated insulin pens. An interview was completed with the DON on 1/24/2024 at 12:46 PM. The DON stated that she expected insulin pens to be dated the day they are opened. An interview was completed with the Administrator on 1/25/2024 at 7:20 AM. The Administrator stated that the nurses were responsible for checking their medication carts for expired and undated medications. She further stated the facility Pharmacy Consultant came	F 761	This audit will ensure all medication carts have no expired or undated inhalers or insulin pens, and no loose pills. Any identified areas of concern will be addressed with retraining immediately. Within the first couple of weeks post hire, new nurses and medication aides will receive continued training on medication cart maintenance to ensure full understanding of drug labeling and storage. Pharmacist will conduct an additional in service with licensed nurses and medication aides on 2/27/24. The Director of Nursing will present findings of the audits to the QAPI committee twice monthly for 3 months to determine if additional audits/training are required. The Director of Nursing will be responsible for ensuring compliance as of 2/13/24.	

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F 761	Continued From page 20 frequently to check for expired medications on the carts and in the medication rooms.	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide adaptive equipment for 1 of 1 resident reviewed for adaptive devices (Resident #29). Findings included: Resident #29 was admitted to the facility on 03/13/15 with diagnosis that included poly-osteoarthritis. A review of Resident #29's current physician orders for regular mechanical soft texture diet regular/thin consistency, house nutritional shake, and special instructions food to be put in a scoop dish for all meals, an adaptive two handled cup with straw and lid at all meals dated 04/13/23. Resident #29 was care-planned for potential dehydration and nutritional problems related to arthritis, adult failure to thrive, weakness, a mechanically altered diet, and Alzheimer's. A listed approach for the care area was to provide	F 810	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to provide adaptive equipment for 1 of 1 resident reviewed for adaptive devices (Resident #29). Resident #29 had an order for an adaptive two-handled cup with a straw and lid at all meals. Resident #29 has not received a two handled cup with straw and lid at all meals. All meal tray tickets were audited for accuracy on 1/24/24 and resident #29 OT eval was completed on 1/25/24. 2. Identification of other residents having the potential to be affected was accomplished by: All residents with assistive eating equipment/utensils have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An audit of all current residents with	2/13/24

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F 810	Continued From page 21 adaptive equipment, scoop dish and a two handled cup) as ordered. The care plan was last revised on 07/05/23. A review of Resident #29's Annual Minimum Data Set (MDS) dated 12/05/23 revealed severe cognitive impairment and required set-up assistance with eating. Observations of the breakfast and lunch meal trays on 01/23/24, 01/24/24, and 01/25/24 found Resident #29 had a scoop dish, but did not receive a two handled adaptive cup on her meal trays and was not listed on the meal ticket. The observations revealed there were no two handle adaptive cups at the ready for the meal trays. An observation of Resident #29 and review of her meal ticket was conducted while she was eating lunch in her room on 01/23/24 at 1:00 PM. The resident was not able to pick up any of the three cups on her meal tray with her arthritic hands but was only able to bend her head over the tray and drink from the water cup, which was the only cup with a straw. The observation found her meal tray did not include a two-handle adaptive cup. A review of Resident #29's meal ticket read mechanical soft diet, and scoop dish. Resident #29 stated she never received an adaptive cup with handles, and she said it would be easier for her to drink from. An interview was conducted with Occupational Therapist (OT) on 01/24/24 at 10:30 AM. She said she was not aware Resident #29 should have had a two-handled drinking cup on her meal trays. She did confirm that Resident #29 did have an active order for a two-handle cup, which included a scoop dish dated 04/13/23. She said	F 810	orders for assistive eating equipment/utensils was completed by the Director of Nursing and Assistant Director of Nursing on 1/25/24. Nursing staff will be re-educated on complying with assistive eating equipment/utensils orders by the Staff Development nurse, Director of Nursing, Assistant Director of Nursing or Administrator. This education was completed 1/30/24. New staff members will be educated by the Staff Development nurse. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning the week of 2/12/24, an audit will be conducted weekly for 12 weeks on a minimum of three random residents with assistive eating equipment/utensils orders to ensure compliance by the Director of Nursing or the Assistant Director of Nursing. The Assistant Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee twice monthly for 3 months and based on the findings determine if additional follow up is required. The Director of Nursing will be responsible for ensuring compliance as of 2/13/24.	

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F 810	Continued From page 22	F 810		

she did observe the resident's breakfast tray that morning and saw that it only had a scoop dish on it, and no two-handled drinking cup. She said the resident needed the cup and would benefit from having one, due to her arthritis, but no cup was on resident's meal ticket or on her breakfast meal tray and should have. per physician's order.

An interview was conducted with the Director of Nursing on 01/24/24 at 12:30 PM. She revealed the dietary department should provide assistive devices including handled cups for residents. DON stated she was not aware that Resident #29 was to have a handled cup and was not getting one for meals. DON stated that she expected residents would be provided with assistive devices for eating and drinking.

An interview was conducted with the Dietary Manager on 01/24/24 at 1:35 PM. She said the staff who pass the trays to the residents will check residents' meal ticket to make sure the resident had what was listed on the ticket, and she said Resident #29's two-handle adaptive cup was not listed on the meal ticket and should have been per review of physician orders. She said she must have transcribed the physician's order wrong and then failed to order a two-handle cup.

An interview was conducted with the Director of Rehab on 01/25/24 at 9:00 AM. He said an adaptive cup was used by residents to prevent spillage and to increase intake. The Rehab Director said if a Nurse Aide (NA) or Nurse identified a resident needed an adaptive cup, it was communicated to rehab department. The Director of Rehab stated Resident #29 had general difficulty getting food and drink to her mouth due to poor range of motion and gripping

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F 810	Continued From page 23 strength. The Rehab Director stated the adaptive cup would help Resident #29 to get drink to her mouth without spilling it. The Rehab Manager stated he was unaware Resident #29 was ordered a two-handle cup on 04/13/23. The Rehab Manager said the resident would be re-evaluated by Occupational Therapy (OT) and a two-handle cup be provided to the resident per physician order. The Administrator was interviewed on 01/25/24 at 2:20 PM and stated when an order was placed into the electronic health record (EHR) it should be reflected on the meal ticket. The Administrator said the order for a two-handle adaptive cup was not placed on the meal ticket, and that the two-handled cup should have been provided to the resident for use.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		2/16/24

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F 812	Continued From page 24 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to: a) ensure leftover food items were labeled and dated when stored in the walk-in refrigerator, b) discard an opened, partially used dairy product that had exceeded the shelf life, and c) ensure the temperature of a cold salad on the tray line was 41 degrees Fahrenheit or below. These practices had the potential to affect food served to residents in the facility. Findings included: During the initial tour of the kitchen on 01/22/24 at 11:15 AM the following was observed in the presence of the Dietary Manager: a. The walk-in refrigerator was observed with the following: a plastic bag of tater tots opened and partially used with no opened date and a partially used bag of shredded lettuce with no opened date. b. The walk-in refrigerator was observed with the following: a plastic bag of opened and partially used shredded cheese dated 01/04/24 (the shelf life was 14 days). c. During an inspection of food temperatures on the tray line on 01/24/24 at 12:20 PM the cold chicken salad temperature taken by the Dietary Manager was 69 degrees Fahrenheit. In an interview with the Dietary Manager on 01/24/24 at 12:48 PM she stated any food that was opened and stored in the walk-in refrigerator	F 812	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to a) ensure leftover food items were labeled and dated when stored in the walk-in refrigerator, b) discard an opened, partially used dairy product that had exceeded the shelf life, and c) ensure the temperature of a cold salad on the tray line was 41 degrees Fahrenheit or below. These practices had the potential to affect food served to residents in the facility. Any items that had exceeded shelf life or were undated/unlabeled were immediately discarded. The cold salad on the tray line was discarded and not served to residents. 2. Identification of other residents having the potential to be affected was accomplished by: All residents that receive oral nutrition have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Labels were made more readily available to dietary staff to promote compliance with dating and labeling leftover food items. All dietary employees received re-education on the posted shelf-life guidelines, as well as education on labeling and dating	

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F 812	Continued From page 25 was to be labeled and dated. She noted the shredded cheese that had been opened on 01/04/24 should have been discarded after 01/18/24 because it had a shelf life of 14 days after opening. The Dietary Manager took the temperature of the cold chicken salad on the tray line. It was 69 degrees Fahrenheit. The salad was immediately discarded. The Dietary Manager commented that cold salad temperatures were usually taken by the cook. In an interview with Cook #1 on 01/24/24 at 12:58 PM she stated she had made the chicken salad that morning. She reported she had mixed the ingredients together and placed the salad in the walk-in refrigerator. She noted she normally would have taken the temperature of the salad, but she had not because she was in a hurry to prepare the meal. In an interview with the Administrator on 01/25/24 at 2:00 PM she stated she expected any food that had been opened to be dated and food that had exceeded the shelf life to be discarded. She also expected temperatures of foods on the tray line to be within specifications and recorded accurately in the temperature log for each meal.	F 812	leftover items. This was completed 1/29/2024. The preparation of cold salads has been modified to exclude the heating of any ingredients. All cooks were educated on this modification, as well as on safe holding cold temperature range by 1/29/2024. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning the week of 2/12/24, an audit will be conducted by the Dietary Manager 5 times a week x 12 weeks to ensure compliance with cold salad temperatures, labeling and dating leftover food items, and adherence to shelf life. The Dietary Manager will report audit findings to the Quality Assurance Performance Improvement Committee twice monthly for 3 months and based on the findings determine if additional follow-up is required. The Administrator will be responsible for ensuring compliance as of 2/16/24.	
F 867 SS=E	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	F 867		2/16/24

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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.

§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

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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, 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

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F 867	Continued From page 28 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 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations, Nurse Practitioner interview, and staff interviews, the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 07/19/21, an on-site revisit survey completed on 09/08/21 and a recertification and complaint investigation survey completed on 0929/22. This was for four repeat deficiencies originally cited in the areas of Pharmacy Srvcs/Procedures/Pharmacist/Records (F755),	F 867	1. The facility has had repeat deficiencies in pharmacy services, medication error, label and storage of biologicals, as well as food procurement, store/prepare/serve-sanitary. 2. All residents have the potential to be affected by this practice. The facility will hold an Adhoc Quality assurance process improvement (QAPI) meeting with the committee on 2/12/24 to develop the plan for improvement in these areas. The committee will include additional licensed	

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F 867	Continued From page 29 Residents Are Free of Significant Med Errors (F760), Label/Store Drugs and Biologicals (F761), and Food Procurement, Store/Prepare/Serve-Sanitary (F812). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F755: Based on record review and staff interviews, the facility failed to secure unused narcotic medications for disposition (the process of returning unused medications to the pharmacy) resulting in possible diversion (the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use). This was for 1 of 1 discharged resident (Resident #256) reviewed for pharmacy services. During the recertification and complaint investigation survey of 09/29/22 the facility failed to acquire and administer omeprazole, a medication used to treat gastroesophageal reflux disorder. F760: Based on record review, staff and Nurse Practitioner interviews, the facility failed to follow the parameter ordered for administration of a medication used to treat diabetes resulting in 7 doses of insulin Glargine 25 units administered in error for 1 of 1 resident (Resident #47) reviewed for medication error. During the recertification and complaint investigation survey of 09/29/22 the facility failed to perform accuchecks to obtain blood sugar	F 867	nurses, corporate support, and pharmacy in the discussion for the improvement plan. 3. The QAPI committee will meet twice monthly for three months with one of the additional meetings focusing only on the repeat deficiencies. The facility contacted the QIO for North Carolina for additional training and resources to improve facility compliance. A call is scheduled with the QIO for 2/16/24 at 12:30 pm to discuss our QAPI plan. 4. The results from the audits will be discussed in detail twice monthly at the QAPI meeting with attention noted to the repeat deficiencies. The QAPI plan will be adjusted according to the results and success of the plans implemented. 5. The Administrator is responsible for the execution of this plan with a compliance date of 2/16/24.	

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readings and administer the scheduled Lispro insulin 5 units along with Lispro sliding scale insulin.

F761: Based on record review, observations and staff interviews, the facility failed to date opened multi-dose inhalers and an insulin pen and failed to discard loose pills in the medication cart drawers for 2 of 6 medication carts (300 Hall and 800 Hall carts).

During the recertification and complaint investigation survey of 07/19/21 the facility failed to dispose of a bottle of aspirin with an illegible expiration date on the bottle, dispose of two expired insulin pens, dispose of unidentified loose pills found in the medication cart, and secure an unattended medication cart.

During the on-site revisit survey of 09/08/21 the facility failed to discard an expired bulk stock medication and two expired insulin pens and failed to put an opened date on an opened insulin pen.

During the recertification and complaint investigation survey 09/29/22 the facility failed to record an opened date for 5 bottles of eye drops, remove an expired insulin pen, and date a bottle of Humalog insulin when opened and to keep unattended medications stored in a locked medication cart.

F812: Based on observation and staff interviews the facility failed to: a) ensure leftover food items were labeled and dated when stored in the walk-in refrigerator, b) discard an opened, partially used dairy product that had exceeded the shelf life, and c) ensure the temperature of a cold

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salad on the tray line was 41 degrees Fahrenheit or below. These practices had the potential to affect food served to residents in the facility.

During the recertification and complaint investigation survey of 07/19/21 the facility failed to routinely monitor and document food temperatures on the steam table by not checking and recording food temperatures of the hot and cold foods prior to serving meals to residents, cover food plates on an open food cart during transportation and distribution to residents, and follow the cleaning schedule for the stovetop, front oven, and deep fryer when a buildup of grease and residue was observed on the equipment.

In an interview with the Administrator on 01/25/24 at 2:00 PM she stated the citation for significant medication errors was for a different reason this year than it was in the past. She attributed the medication storage citation repetition to the hiring of new staff and the use of pens to label and date medicines that wore off during day to day use.