STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 03/06/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 03/03/24 through 03/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8OFL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 03/03/24 through 03/06/24. Event ID# 8OFL11. The following intakes were investigated NC00209038, NC00208982, NC00209118, NC00210264, NC00210309. 1 of the 18 complaint allegations resulted in deficiency.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		3/23/24

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

Electronically Signed | 03/25/2024

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F 644	Continued From page 1 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer residents with serious mental health diagnoses for a Preadmission Screening and Resident Review (PASRR) level II screening for 1 of 3 residents reviewed for PASRR (Resident #38). The findings included: Review of Resident #38's Hospital Discharge Summary dated 2/02/23 revealed no diagnosis of schizophrenia. Resident #38 was admitted to the facility on 2/02/23 with diagnoses which included major depressive disorder and anxiety. Review of Resident #38's Preadmission Screening and Resident Review (PASRR) Level I Determination Notification dated 3/24/23 revealed Resident #38 required no further screening unless a significant change occurred which suggested a diagnosis of mental illness. Review of the Minimum Data Set (MDS) annual assessment dated 2/02/24 revealed Resident #38 was cognitively intact and was coded for anxiety, depression, and schizophrenia. Resident #38 was not coded for behaviors. Review of Resident #38's active diagnosis list on 3/03/24 revealed Resident #38 had a diagnosis of schizophrenia which was created on 10/20/23 with an active date of 6/23/23. An interview was conducted on 3/05/24 at 9:10	F 644	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F644 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/12/2024 the Social Worker (SW) submitted PASRR for resident 38. It was submitted and accepted on 3/19/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 3/12/2024 the SW began completing a 100% audit of current resident records to ensure that appropriate residents with serious mental health diagnoses have a Preadmission Screening and Resident Review (PASRR) level II screening when needed. This audit resulted in 14 residents needing referral. On 3/12/2024 the SW implemented corrective action for these residents which included completing new referrals. This was completed on	

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F 644	Continued From page 2 am with the Social Worker who revealed she was responsible to submit notification for PASRR review for Resident #38, but she stated she was unable to recall being notified of Resident #38's schizophrenia diagnosis. The Social Worker stated she would have submitted a review of Resident #38's PASRR Level I based on the new diagnosis of schizophrenia. An interview was conducted with the Administrator on 3/06/24 at 10:37 am who revealed the Social Worker was responsible for Resident #38's PASRR review.	F 644	3/22/2024. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/6/2024 the Nurse Consultant completed education with the facility Social Worker, Administrator, Administrative Nurses, Health Information Manager, and Admissions Coordinator which included the PASARR assessment process and requirements for when a PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a PASARR referral. On 3/7/2024 Administrator made the Health Information Manager aware of responsibility of notifying the Social Worker of when a new diagnosis has been added that would potentially qualify a resident for a new PASARR and made Social Worker aware of responsibility of requesting a PASRR review when indicated. Any Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 3/22/2024 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees in the above listed positions. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 644	Continued From page 3	F 644	and/or in compliance with regulatory requirements. The Director of Nursing (DON) or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the DON or designee to ensure corrective action is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		3/23/24

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F 655	Continued From page 4 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review the facility failed to ensure a baseline care was completed within 48 hours after admission and failed to complete all sections of the baseline care plan for a new admission for 1 of 3 residents (Resident #63) reviewed. The findings included: Resident #63 was admitted into the facility on 2/01/24 with diagnoses of cancer, dialysis, and diabetes.	F 655	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 655	Continued From page 5 A review of Resident #63's medical record showed that the baseline care plan was started on 2/1/24 and had only one section completed, which was medication regimen section. The general information section was completed on 2/3/24. Resident #63's health conditions, dietary, therapy and social services were not completed. A review of Resident #63's admission Minimum Data Set dated 2/8/24 noted he was severely cognitively impaired, was dependent on staff for his activities of daily living, was incontinent of bowel and was receiving dialysis. In an interview on 3/5/24 at 8:20 AM the Director of Nursing (DON) indicated the Social Worker (SW) was responsible for the care plans, as the MDS Nurse was part time. In an interview on 3/5/24 at 9:24 AM the Administrator indicated that the base line care plan begins with the Social Worker. In an interview on 3/5/24 at 11:15 AM the Minimum Data Set (MDS) Nurse stated that she works part time to help out. She indicated for a new admission; she checks the care plan to see if the nursing team has entered the resident care details. The MDS nurse indicated the Social Worker handled the baseline care plans.	F 655	F655 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident 63s baseline care plan (CP) was completed on 3/19/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 3/15/2024 the Director of Nurses (DON) initiated an audit of all current residents admitted during the last 30 days to identify any residents who did not have a base line care plan completed within 48 hours of their admission. The audit was completed on 3/15/2024. The audit resulted: 7 of 14 residents did not have base line care plans completed. On 3/22/2024 the Interdisciplinary Team (IDT) (includes - DON, Social Worker, Therapy Director, Registered Nurse, Support Nurse, Activity Director, and MDS Nurse) ensured that all residents who did not have base line care plans were immediately corrected and a baseline care plan was completed for them. On 3/7/2024, the Nurse Consultant began reeducating members of the IDT on the following topics: " Timeline and steps necessary for Initiating a Base Line Care Plan. " Those who are responsible for Base Line Care Plan. " Review of the Base Line Care Plan Requirements.	

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F 655	Continued From page 6	F 655	" The need to review the Base Line Care Plan Requirements. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/7/2024, the Nurse Consultant began reeducating members of the IDT on the following topics: " Timeline and steps necessary for Initiating a Base Line Care Plan. " Those who are responsible for Base Line Care Plan. " Review of the Base Line Care Plan Requirements. " The need to review the Base Line Care Plan Requirements. " This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/22/2024 any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 655	Continued From page 7	F 655	requirements. The Director of Nursing or designee will monitor compliance utilizing the F655 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor for compliance with initiating base line care plans within the specified time frame and provide the resident and/or their representative with a summary of the baseline care plan. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Assistant Director of Nurses, Minimum Data Set Nurses, Therapy Manager, RN Unit Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		3/23/24

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F 698	Continued From page 8 by: Based on observations, record review, resident and staff interviews, and Medical Director interview, the facility failed to obtain and implement physician orders for the care and monitoring of a resident on hemodialysis for 1 of 2 residents for dialysis (Resident #15). The findings included: Resident #15 was admitted to the facility on 5/01/23 with diagnoses which included end stage renal disease (ESRD) with dependence on dialysis. Review of the care plan last revised on 8/31/23 revealed Resident #15 received hemodialysis (a machine filters waste from the body when the kidneys no longer work adequately) three times a week due to renal disease. The interventions included applying firm and direct pressure using two fingers to bleeding shunt or port site, and do not draw blood or take blood pressure on the arm with shunt or graft (catheter access area for delivery of hemodialysis). Resident #15 had an active physician order dated 10/19/23 for dialysis on Tuesday, Thursday, and Saturday. Review of the arteriovenous graft (AVG) surgery discharge summary dated 1/15/24 revealed Resident #15 had an arteriovenous (AV) fistula (an artery and vein joined surgically to administer dialysis) placed in the right upper arm. An attempt to interview Nurse #3, who was assigned to Resident #15 on 1/15/24, via telephone on 3/04/24 at 2:04 pm was	F 698	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F698 1. Corrective action for resident affected by the alleged deficient practice: On 03/04/2024, The Registered Nurse Supervisor (RN) provided a corrective action for resident 15 when the RN reviewed the consult report from 2/28/2024 and updated the residents order to reflect the correct access site and any new orders. On 3/4/2024 the Administrative Nurses 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current Dialysis residents in the facility have the potential to be affected. On 03/07/2024, 100% of all residents receiving dialysis services were audited by the Director of Nurses (DON), Registered Nurse Supervisor (RN), and Support Nurse (SN). They had direct observation of each resident's access site to ensure it was correct in the orders. On 3/7/2024 the Administrative Nursing Team (DON,	

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F 698	Continued From page 9 unsuccessful. Review of the dialysis communication note to nurse dated 1/16/24 revealed the dialysis center requested the facility to note on resident chart for no intravenous (IV) or blood pressure (BP) in the right arm. A review of Resident #15's active physician orders revealed no orders for monitoring of the right arm AV fistula, no IV in the right arm, and no blood pressure check on the right arm. Review of the Minimum Data Set (MDS) quarterly assessment dated 2/09/24 revealed Resident #15 was cognitively intact and was coded for dialysis. An interview and observation was conducted on 3/04/24 at 12:40 pm with Resident #15 who revealed she received her dialysis through the right arm AV fistula. Resident #15 stated the nursing staff did not check her right arm AV fistula site every shift. Resident #15's AV fistula site was observed to be in the upper right arm and there was no documentation observed in the resident medical record about no blood pressures or IV from the right arm. An interview was conducted on 3/04/24 at 12:53 pm with Nurse #2 who revealed when a resident returned from dialysis the access site was checked for bleeding, vital signs were obtained, and the post-dialysis weight from the dialysis communication binder was entered into the medical record. Nurse #2 reported she did not see a physician order to check the AV fistula site for Resident #15. Nurse #2 stated she believed an AV fistula site was assessed once a shift for bruit (a whooshing sound heard at the fistula site	F 698	Registered Nurse Supervisor, and Support Nurse) reviewed communication from the dialysis centers from the past 4 weeks. No other concerns noted. This was completed on 3/10/2024. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 03/07/2024, the DON implemented a new process for ongoing communication documentation with the hemodialysis center which includes the following: The DON or designee will provide oversite of Nurses to ensure communication is obtained and implemented for care and monitoring for residents on hemodialysis. Any of the above staff who did not receive in-service training by 03/22/2024 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 698	Continued From page 10 with a stethoscope) and thrill (vibration caused by blood flow felt with fingers) but stated she would have to check to be sure since there was not a physician order. During an interview on 3/04/24 at 1:20 pm the Registered Nurse (RN) Supervisor stated when Resident #15 returned from the surgical procedure for the AV fistula the nurse that received the discharge information should have entered physician orders for the fistula site care which would include shunt procedures for bleeding, monitoring for bruit and thrill, and no BP or IV in the arm that the fistula was in. She further stated the dialysis communication book was to be reviewed upon Resident #15's return from dialysis and the nurse should have completed the recommendations as requested by dialysis regarding no BP or IV in the right arm. The RN Supervisor stated the dialysis communication books were reviewed during the morning clinical meeting, but she was unable to state how the communication from dialysis regarding no blood pressure or IV in the right arm was missed for Resident #15. Interviews were conducted on 3/05/24 at 9:41 am and 3/06/24 at 8:53 am with the Support Nurse who revealed the nurse that received the dialysis communication book was responsible for the review and completion of the recommendations for no BP or IV for Resident #15's right arm. The Support Nurse further reported when Resident #15 returned from the AV fistula procedure the instruction sheet should have been reviewed by the receiving nurse and if any orders were needed the nurse should have contacted the physician. The Support Nurse was unable to state how the orders for Resident #15's AV fistula site	F 698	requirements. The DON or designee will monitor compliance utilizing the F698 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor for compliance with dialysis processes. Reports will be presented to the weekly Quality Assurance committee by the RN or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/23/2024	

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F 698	Continued From page 11	F 698		

monitoring and no BP or IV in the right arm were missed.

An interview with the Medical Director was conducted on 3/05/24 at 10:24 am. The Medical Director stated she was not aware there were no orders for monitoring of the AV fistula site and did not know how the orders to monitor the site were overlooked. The Medical Director stated Resident #15's AV fistula should have had orders in place which included monitoring for bruit and thrill.

An interview was conducted on 3/05/24 at 3:20 pm with Nurse #5 who revealed she was aware of Resident #15's right arm AV fistula but did not realize there were not physician orders to monitor the fistula, and for no BP or IV in right arm. Nurse #5 stated when Resident #15 returned from dialysis she often left her room right away to go visit with other residents or go outside so she was not always able to check her fistula, but she would try. Nurse #5 stated she was aware the fistula site had to be checked every day, and that no BP or IV was to be done in the right arm but she did not check to see if the physician orders were entered for Resident #15.

An interview was conducted with the Director of Nursing (DON) on 3/06/24 at 10:34 am who revealed the nurse assigned to Resident #15 was responsible to review the surgical discharge summary upon the residents return and leave the summary to be reviewed by the DON for follow-up to make sure all necessary orders were entered. The DON stated she believed Resident #15's AV fistula surgical discharge summary was received by the nurse but was not left for her to review. The DON further stated the nurses were

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F 698	Continued From page 12 to monitor the AV fistula site for bleeding, and the bruit and thrill were to be checked every shift. The DON stated the nurse who was assigned to Resident #15 should have reviewed the dialysis communication binder when she returned from treatment and completed the recommendations sent for no BP or IV in the right arm in the resident record and in the room. The DON was unable to state how the physician orders for the AV fistula site monitoring and the dialysis communication recommendations were missed for Resident #15. During an interview on 3/06/24 at 10:34 am the Administrator stated Resident #15's AV fistula surgical discharge summary was to be reviewed by the nurse that was assigned when the resident returned and if any orders were needed, they were expected to obtain the orders. The Administrator stated the discharge summary was to be left for the DON to review and follow-up as needed during the daily clinical meeting.	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		3/23/24

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F 756	Continued From page 13 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner, Consultant Pharmacist, and Medical Director interviews the facility failed to attempt a gradual dose reduction (GDR) per Consultant Pharmacist recommendations of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #38). The findings included: Resident #38 was admitted to the facility on 2/02/23 with diagnoses which included anxiety, insomnia, and major depressive disorder.	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756	

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F 756	Continued From page 14 Resident #38 did not have a diagnosis of schizophrenia upon admission to the facility. The Minimum Data Set (MDS) annual assessment dated 2/02/24 revealed Resident #38 was cognitively intact and was not coded for behaviors. Resident #38 was coded for anxiety, depression, and schizophrenia and they received antipsychotic, hypnotic, and antidepressant medications. The MDS annual assessment noted Resident #38 had not had a gradual dose reduction (GDR) of the antipsychotic medication and there was no documentation of clinical contraindications (inadvisable because of harm to person) related to a GDR attempt. A review of Resident #38's hospital discharge summary dated 2/02/23 revealed Resident #38 was discharged from the hospital with the following medications: paliperidone (an antipsychotic medication used to treat schizophrenia and schizoaffective disorder) 1.5 milligrams (mg) 3 tablets every morning, bupropion extended release (an antidepressant medication) 300 mg daily, and zolpidem (hypnotic, sedative medication used for insomnia) 5 mg at night. Review of Resident #38's active physician orders on 3/06/24 revealed the following: An active physician order with a start date of 2/03/23 for paliperidone 1.5 mg tablet give 3 tablets daily. An active physician order with a start date of 2/03/23 for bupropion extended release 300 mg daily. An active physician order with a start date of 2/03/23 for zolpidem 5 mg tablet at bedtime. An active physician order dated 2/21/24 for	F 756	1. Corrective action for resident affected by the alleged deficient practice: On 3/18/2024 the Gradual Dose Reductions (GDR) was completed for resident # 38 by the Medical Director. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 3/6/2024 the Registered Nurse Supervisor (RN) audited all current residents GDRs reported from the Consultant Pharmacist (PharmD) for the last 2 months for completion. The PharmD identified 100% of all current residents with a pending GDR. The RN reviewed 100% of the GDRs and forwarded needed updates to the provider. This audit was completed on 3/7/2024. The results included 6 of the 20 residents audited needed GDR updates. This was completed on 3/21/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/6/2024 an in-service education was provided to the Director of Nursing and Nurse Managers by the Nurse Consultant on the GDR process. Topics included: Pharmacy recommendations include review for unnecessary drugs. Pharmacy recommendations must be completed upon receipt. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used. — In excessive dose (including duplicate	

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F 756	Continued From page 15 outpatient psychiatric appointment for routine follow-up. Review of the Note to Attending Physician/Prescriber dated 8/23/23 revealed the Consultant Pharmacist notified the attending physician that it was time to evaluate psychoactive medications for a GDR. The following medications were listed for possible GDR: zolpidem 5 mg at night, bupropion extended release (ER) 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The Nurse Practitioner (NP) response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. Review of the Note to Attending Physician/Prescriber dated 11/15/23 revealed the Consultant Pharmacist sent a follow-up to the 8/23/23 notification regarding GDR recommendation for Resident #38. The Consultant Pharmacist notified the attending physician that it was time to evaluate psychoactive medications for a GDR for the following medications: zolpidem 5 mg at night, bupropion extended release (ER) 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The NP response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. Review of the Note to Attending Physician/Prescriber dated 12/13/23revealed the Consultant Pharmacist notified the provider that a signed note in Resident #38's medical record in November 2023 regarding GDR review for psychoactive medications, that the resident was seen by outside psychiatric provider. Please	F 756	drug therapy) — For excessive duration — Without adequate monitoring — Without adequate indications for its use — In the presence of adverse consequences which indicate the dose should be reduced or discontinued. On 3/6/2024 the nurse managers began educating all full time, part time, and PRN Nurses on the following topics: Pharmacy recommendations include review for unnecessary drugs. Pharmacy recommendations must be completed upon receipt. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used. — In excessive dose (including duplicate drug therapy) — For excessive duration — Without adequate monitoring — Without adequate indications for its use — In the presence of adverse consequences which indicate the dose should be reduced or discontinued. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. After 3/22/2024 any staff who has not received scheduled in-service training	

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F 756	Continued From page 16 send the GDR request to their office for review and return to the facility. The Consultant Pharmacist reported it was time to evaluate Resident #38's psychoactive medications for a GDR. The following medications were listed for possible GDR: zolpidem 5 mg at night, bupropion extended release 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The NP response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. Review of the Medication Regimen Review dated 1/16/24 revealed the Consultant Pharmacist notified the provider that according to documentation in the medical record, Resident #38 received outpatient psychiatric services. The Consultant Pharmacist requested the provider follow-up on obtaining the most recent consultations for review. The Consultant Pharmacist further noted they needed the documentation to ensure GDRs were monitored for hypnotic and antidepressant medication. Review of the Medical Director Progress Note dated 2/02/24 revealed Resident #38 was seen for a regulatory visit with chronic health problems being addressed which included schizophrenia. The Medical Director noted Resident #38 was under the care of an outpatient psychiatrist with no new symptoms or exacerbations reported during the visit. Review of the care plan revised on 2/24/24 revealed Resident #38 received antipsychotic medication related to diagnosis (no diagnosis noted) and received an antidepressant medication related to depression. Resident #38 was at risk for adverse side effects with	F 756	will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F756 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The Director of Nursing will review completion of pharmacy recommendations for any unnecessary drugs. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	

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interventions for the Consultant Pharmacist to review my psychotropic medication quarterly and as needed for possible changes or reductions.

Review of Resident #38's electronic medical record revealed no documentation of outpatient psychiatric appointments or supporting clinical documentation regarding contraindications for GDR attempts from the outpatient psychiatric provider.

Interviews were conducted on 3/06/24 at 8:45 am and 10:15 am with the Support Nurse who revealed Resident #38 was followed by an outpatient psychiatrist, but the facility had not received any documentation regarding his care. The Support Nurse stated she had tried to call the outpatient psychiatrist and was unable to make contact. The Support Nurse stated Resident #38 was reportedly seen by the outpatient psychiatrist via telehealth in July of 2023, but the facility was unable to locate any information regarding the visit and was unable to determine who assisted Resident #38 with the telehealth call.

A telephone interview was conducted on 3/06/24 at 10:09 am with the Consultant Pharmacist who revealed the facility was notified that the notation that Resident #38 was followed by outpatient psychiatry was not a sufficient response to the GDR recommendation. The Consultant Pharmacist stated they were unable to locate any outpatient psychiatric documentation on Resident #38's medical record to state a GDR was clinically contraindicated and had asked the facility on multiple occasions to obtain documentation to ensure Resident #38's psychotropic medications were being monitored.

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F 756	Continued From page 18 An interview was conducted on 3/06/24 at 11:35 am with the Nurse Practitioner (NP) who revealed she was told Resident #38 was followed by outpatient psychiatrist. The NP stated she had asked the facility many times to obtain the outpatient psychiatrist visit records so she could review the information, but she had not received any documentation. An attempt to interview the Medical Director via telephone was unsuccessful on 3/06/24 at 11:53 am. The Medical Director returned the call on 3/07/24 2:31 pm and reported she had requested Resident #38's outpatient psychiatrist documentation but the facility had not received the information. The Medical Director stated the normal process for residents that were prescribed psychotropic medication was to be followed by the in-house psychiatric provider, but she was told Resident #38 was followed by outpatient provider. During an interview on 3/06/24 at 12:30 pm the Administrator stated the Support Nurse worked with the NP regarding Resident #38's outpatient psychiatric visits. The Administrator stated she would have to speak to the Support Nurse regarding the issue of obtaining Resident #38's outpatient psychiatric information.	F 756		
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	F 761		3/23/24

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F 761	Continued From page 19 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 observation and staff interviews the facility failed to label and date an open bottle of eye drops for one of two medication carts observed for medication storage (Hall 400). The findings included: During an observation of the 400 Hall medication cart on 3/04/24 at 8:59 am in the presence of Nurse #1 a squeeze bottle of prednisolone acetate ophthalmic suspension 1% (steroid medication used to treat inflammation of the eyes caused by certain conditions) was in the top drawer, opened, with no open date noted on bottle, and there were no resident identifiers on the bottle. At the time of the observation, an interview was	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident affected by the alleged deficient practice: On 3/4/2024 the Registered Nurse Supervisor (RN) discarded the unlabeled open bottle of eye drops from the 400-hall	

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F 761	Continued From page 20 conducted with Nurse #1 who confirmed the squeeze bottle of the prednisolone acetate ophthalmic suspension 1% medication was opened, did not have the date the bottle was opened, and had no resident identifiers. Nurse #1 stated she did not know when the medication was opened or where the bag that had the resident name on it went. She stated the medication was for a resident on the hall and she confirmed she had already administered the medication. Nurse #1stated she knew which resident the medication belonged to because there was only resident prescribed the medication on her cart. Nurse #1 removed the prednisolone acetate ophthalmic suspension 1% from the medication cart. An interview was conducted on 3/06/24 at 9:20 am with the Director of Nursing (DON) who revealed Nurse #1 should not have used the eye drops without resident identification on the bottle. The DON stated Nurse #1 should have reordered the medication from the pharmacy. During an interview on 3/06/24 at 10:57 am the Administrator stated Nurse #1 should have discarded the medication without the resident information available.	F 761	medication cart and educated the Nurse assigned to that medication cart. 2. Corrective action for all residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 3/4/2024, the Director of Nurse (DON), Registered Nurse Supervisor (RN) and Support Nurse (SN) audited all medication carts, treatment carts, and medication rooms and removed any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. No resident was found to be affected by the deficient practice. In order to ensure that no resident is affected, a continued daily audit of the facility medication carts, treatment carts, and medication rooms was conducted by the RN and SN to ensure there were no drugs and biologicals that were not labeled in accordance with currently accepted professional principles. This will include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrections will be made immediately where indicated. Random peer audits were initiated on medication and treatment carts on various shifts through 3/22/2024. Daily administrative	

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F 761	Continued From page 21	F 761	team audits will be ongoing, including weekends, and reported to Quality Assurance (QA) committee weekly by the RN. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/8/2024, the DON/designee began educating all full time, part time, agency staff, and PRN Licensed Nurses, Registered Nurses, Licensed Practical Nurses, and Medication Aides on the following topics: • Checking medications for labeling and expiration date prior to administering the medication. • Labeling medications to include date opened as indicated. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/22/2024, any staff who has not received scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will	

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F 761	Continued From page 22	F 761	monitor compliance utilizing the F761 Quality Assurance Tools weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling drugs and biologicals to ensure that they are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Peer medication/treatment cart audits will be ongoing randomly. Reports of all audits will be presented to the weekly Quality Assurance committee by the DON/designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		3/23/24

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§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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F 842	Continued From page 24 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Consultant Pharmacist, Nurse Practitioner, and Medical Director interviews, the facility failed to obtain outpatient psychiatrist visit notes for a resident prescribed psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #38) The findings included: Resident #38 was admitted to the facility on 2/02/23 with diagnoses which included anxiety, insomnia, and major depressive disorder. Review of the Medication Regimen Review dated 1/16/24 revealed the Consultant Pharmacist notified the provider that according to documentation in the medical record, Resident #38 received outpatient psychiatric services. The Consultant Pharmacist requested the provider follow-up on obtaining the most recent	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 The facility failed to have complete and accurate medical records in the area of Outside Providers documentation. 1. Corrective action for resident affected by the alleged deficient practice: On 3/5/2024 the Health Information Manager (HIM) requested medical records for resident # 38 from the	

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F 842	Continued From page 25 consultations for review. Review of Resident #38's medical record revealed no documentation of outpatient psychiatric appointments or supporting clinical documentation from the outpatient psychiatric provider. An interview was conducted on 3/06/24 at 8:45 am with the Support Nurse who revealed Resident #38 was followed by an outpatient psychiatrist, but the facility did not have any documentation regarding his outpatient psychiatric appointments. She stated Resident #38 was reportedly seen by the outpatient psychiatrist via telehealth in July of 2023, but the facility was unable to locate any information regarding the visit and was unable to determine who assisted Resident #38 with the telehealth call. The Support Nurse stated she was unable to contact the outpatient psychiatric provider to obtain the records for Resident #38 because the office does not answer the phone. A telephone interview was conducted on 3/06/24 at 10:09 am with the Consultant Pharmacist reported they were unable to locate any outpatient psychiatric documentation on Resident #38's medical record and had asked the facility on multiple occasions to obtain documentation to ensure Resident #38's psychotropic medications were being monitored. An attempt to contact the outpatient psychiatrist provider on 3/06/24 at 10:21 am was unsuccessful. An interview was conducted on 3/06/24 at 11:35 am with the Nurse Practitioner (NP) who revealed	F 842	provider. HIM received and uploaded the documents on 3/6/24. The Director of Nurses (DON) reviewed the documents on 3/6/2024 and found no new orders or follow-up required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents are potentially at risk for the deficient practice. On 3/19/2024 the Director of Nurses & Registered Nurse Supervisor (RN), initiated an audit of current residents that had been seen by outside providers in the last 30 days. The audit consisted of a review of the documents returned from the appointments for any orders or follow-up. 43 residents went out in the past 30 days to see outside providers. No new orders identified so no need for any clarifications. Nurse Supervisor completed this on 3/21/2024. On 3/15/2024, the Administrator, Director of Nursing , and the RN Nurse Supervisor put in place the process for the steps that will be taken to prevent future occurrences. This will include the DON, Nurse Supervisor, Support Nurse, HIM and the Transportation Scheduler monitoring for returned paperwork after each appointment. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 842	Continued From page 26 she was told Resident #38 was followed by outpatient psychiatrist, but the facility did not have any of the records from the outpatient psychiatrist. The NP stated she had asked the facility many times to obtain the outpatient psychiatrist visit records so she could review the information, but she stated she had not received any documentation.	F 842	Beginning on 3/15/2024 the Administrative Nurses began in-service education of all full time, part time, as needed, agency nurses, Registered and Licensed Practical Nurses. • The learner will understand the importance of ensuring that there is documentation after each appointment. • Confirming that orders are documented following completion of the appointment. • Notification of the MD/RP of any new orders after an appointment • Appointment process. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. After 3/22/2024 any of the identified nursing staff who has not received scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses, or designee will monitor compliance utilizing the F 842 Audit Tool weekly x 3 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly Quality	

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F 842	Continued From page 27	F 842	Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/23/2024	
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	F 867		3/23/24

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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 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

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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 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)

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F 867	Continued From page 30 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 observations, record review, and staff interviews, 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 7/28/21 recertification and complaint investigation, the 10/1/21 revisit survey, and the 10/5/23 complaint investigation. This was for two deficiencies cited in the area of Label/Store Drugs and Biologicals and Influenza/Pneumococcal Vaccines. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag was cross-referenced to: F761: Based on observation and staff interviews the facility failed to label and date an open bottle of eye drops for one of two medication carts observed for medication storage (Hall 400). During the recertification and complaint investigation survey of 7/8/21, the facility failed to	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/8/2024, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Influenza/Pneumococcal Immunizations (F883) and Label/Store Drugs and Biologicals (F761).	

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F 867	Continued From page 31 keep an unattended medication cart locked, an unattended treatment cart locked, medication cart drawers free of loose medications, and to discarded expired medications. During the revisit survey of 10/1/21, the facility failed to keep an unattended treatment cart, containing medicated treatments locked. During the complaint investigation survey of 10/5/23, the facility failed to: discard 2 vials of an expired controlled substance (Ativan) stored in a locked box in the medication room refrigerator, and date an opened vial of insulin stored in the medication cart. The Administrator was interviewed on 3/06/24 at 12:01 PM. She revealed that medication cart audits were performed daily, and ongoing education was provided during audits and if issues arose. The cart in question had an audit performed on 3/2/24. The Administrator stated that the medication cart audit was not performed on 3/3/24 due to the entrance of the state survey team. If any medication (or eye drops) were not labeled and dated, they should be discarded, and a replacement would be retrieved from the backup pharmacy. F883: Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents reviewed for immunizations (Resident #19 and Resident #43). During the recertification and complaint investigation survey of 7/28/21, the facility failed to offer the Pneumococcal Polysaccharide Vaccine (PPSV23) a year following the	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Influenza/Pneumococcal Immunizations and Label/Store Drugs The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 3/13/2024 to review the deficiencies from the annual recertification survey completed on 3/6/2024 and reviewed the pending citations with a plan of correction (POC) completed. On 3/6/2024, the Nurse Consultant in-serviced the facility Administrator and the Director of Nursing on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Immunizations (F883) and Label/Store Drugs (761). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 03/8/2024, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Influenza/Pneumococcal vaccine (F883) and Label/Store Drugs (761). Team members include: Administrator, Director of Nurses, Minimum Data Set – Registered Nurse, Health Information Manager, Support Nurse, and Registered Nurse -Supervisor.	

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F 867	Continued From page 32 Pneumococcal Conjugate Vaccine (PCV13) for a resident who had consented to Pneumococcal bacteria vaccination.	F 867	This in-service is incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. After 3/22/2024 any QAPI team members who have not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool monthly x 3 months. The tool will monitor facility identified concerns including F883 and F761 that need to be addressed by the QA Committee. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting until no longer deemed necessary. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		3/23/24

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F 883	Continued From page 33 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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F 883	Continued From page 34 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to offer the pneumococcal vaccine for 1 of 5 residents (Resident #19) and administer the pneumococcal vaccine to eligible residents for 1 of 5 residents reviewed for immunizations (Resident #43). The findings included: 1. Resident #19 was admitted to the facility on 1/26/24 with a diagnosis of intracranial injury with loss of consciousness. Review of Resident #19's admission packet dated 1/26/24 revealed Resident #19's responsible party (RP) gave authorization for the pneumococcal vaccine to be administered. The Minimum Data Set (MDS) admission assessment dated 2/2/24 revealed Resident #19 was severely cognitively impaired and was not offered the pneumococcal vaccine.	F 883	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F883 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility did not follow processes as outlined in the policies and procedures to ensure that Residents 19 and 43 were assessed for the eligibility of and offered the pneumococcal vaccines including utilization of the Vaccine Information	

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F 883	Continued From page 35 As of 3/4/24 there was no documentation of the pneumococcal vaccine being provided to Resident #19. Review of Resident #19's immunization record on 3/5/24 revealed that the pneumococcal vaccine was labeled as "consent refused." An interview was conducted with the Infection Preventionist/Support Nurse on 03/05/24 at 8:57 AM. She revealed that vaccinations were offered to residents upon admission. If consent was given, then an order would be entered on the resident's medication administration record. Then the vaccine would be ordered from the pharmacy, and all vaccine activity would be documented under the immunization tab in the medical record. Resident #19 consented for the pneumococcal vaccine. She stated she was unsure why the immunization record showed consent refused. The Infection Preventionist indicated Resident #19 was supposed to receive the pneumococcal vaccine based on the consent records. Review of a health status note dated 3/5/24 at 12:32 PM and written by the Infection Preventionist revealed that Resident #19 was offered the pneumococcal vaccine, and he declined. Resident #19 was adamant that he did not want any further vaccines. The RP was notified and said it was fine if Resident #19 did not accept the pneumococcal vaccine. Resident #19's RP was interviewed on 3/05/24 at 1:37 PM. He revealed that the pneumococcal vaccine was important for Resident #19 to remain healthy. The RP stated that he was not sure if Resident #19 received the pneumococcal vaccine at his previous facility.	F 883	Sheet (VIS) to provide education to the residents and the resident representatives. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident 19 was assessed and offered the pneumococcal vaccine. He initially declined the vaccine. The nurse reviewed and offered the pneumococcal vaccine again and the vaccine was administered on 3/18/2024. MD was informed. Family was informed. Resident 43 was assessed and offered the pneumococcal. The pneumococcal vaccine was administered 3/5/2024. MD was informed. Family was informed 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who have not been assessed and offered the pneumococcal vaccine have the potential to be affected by the alleged deficient practice. On 3/5/2024 a corrective action was initiated. The Director of Nurses/Nurse Managers completed a 100% audit to assess any residents who were eligible and didn't receive the pneumococcal. Audit was completed on 3/11/2024. Any residents who were not vaccinated were assessed and offered the pneumococcal vaccine according to facility policy. The Director of Nurses/Nurse Managers followed up with the residents and any family representatives for any residents who were identified as not receiving the	

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	345358	A. BUILDING _____ B. WING _____	C 03/06/2024

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F 883	Continued From page 36 During a follow-up interview with Resident #19's RP on 3/05/24 at 1:50 PM, he stated that he called the previous facility and there was no record of the pneumococcal vaccine provided to Resident #19. The RP indicated that it was important for Resident #19 to receive the vaccine and would like them administered to stay healthy. During an interview with the Administrator on 03/05/24 at 2:01 PM, she revealed that all vaccines must be consented or declined upon admission. The pneumococcal vaccine needed to be ordered from the pharmacy. If the resident or RP gave consent, they would receive the vaccine when available. The Administrator stated that the Treatment Nurse should have documented the refusal in Resident #19's medical record. 2. Resident #43 was initially admitted to the facility on 3/14/23 with a diagnosis of encephalopathy. Review of Resident #43's admission packet dated 3/14/23 revealed Resident #43's RP gave authorization for the pneumococcal vaccine to be administered. The Minimum Data Set (MDS) significant change assessment dated 12/15/23 revealed Resident #43 was severely cognitively impaired and was not offered the pneumococcal vaccine. Review of Resident #43's immunization record on 3/5/24 revealed that the pneumococcal vaccine was labeled as "immunization required" and not given. An interview was conducted with the Infection	F 883	pneumococcal vaccine during this audit to provide education for the vaccine. There were no adverse events and no cases of pneumonia diagnosed for any residents who have not received a pneumonia vaccine. Residents who consented to the pneumococcal and influenza vaccine have been vaccinated and their medical record has been updated as of 3/22/2024. Residents who declined the pneumonia vaccine have the declination updated in their records according to the facility policy as of 03/22/2024. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Education: The Director of Nurses and the Nurse Management team were re-educated on the immunization policy and procedures by the Clinical Nurse Consultant. The education included the following topics: • Education to the resident or resident's representative of the benefits and potential adverse side effects of the vaccination. • Obtaining of consent for administration of the vaccinations. • Uploading the consent or declination in the resident's medical record. • Obtaining a physician's order to administer the vaccinations. • Administration of the vaccines. • Documentation of the vaccinations in	

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F 883	Continued From page 37 Preventionist/Support Nurse on 3/05/24 at 8:57 AM. She revealed that vaccinations were offered to residents upon admission. If consent was given, then an order would be entered on the resident's medication administration record. Then the vaccine would be ordered from the pharmacy, and all vaccine activity would be documented under the immunization tab in the medical record. Resident #43's RP consented for the pneumococcal vaccine to be administered dated 3/14/23. The immunization record showed that the immunization was required, which meant that Resident #43 should have received the pneumococcal vaccine. During an interview with the Administrator on 3/05/24 2:01 PM, she revealed that all vaccines must be consented or declined upon admission. The pneumococcal vaccine needed to be ordered from the pharmacy. If the resident or RP gave consent, they would receive the vaccine when available. The Administrator indicated that nursing staff should have contacted the provider to notify them that Resident #43 wanted the pneumococcal vaccine, but its arrival was pending. She stated that Resident #43 should have received the pneumococcal vaccine soon after admission.	F 883	the resident's immunization record. • Utilizing the Immunization Check list for pneumococcal vaccines On 3/11/2024 the Director of Nurses/Nurse Management team began education of all full time, part time and as needed nurses and agency nurses on the Pneumococcal administration process. The in-service was completed on 3/22/2024. The Director of Nurses will ensure that that any of the above identified staff who did not complete the in-service training by 3/22/2024 will not be allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Unit Managers will monitor the immunization process for pneumococcal utilizing the F883 Audit Tool during for compliance of the facility policy. This audit will be completed weekly for a period of 3 weeks and then monthly for a period of 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. The Clinical Team will review in the Quality Assurance Meeting weekly until resolved. Compliance will be monitored and the ongoing auditing program reviewed at the	

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F 883	Continued From page 38	F 883	weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nurses, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/23/2024	