STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 11/12/24 through 11/15/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # XH9I11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/12/24 through 11/15/2024. Event ID# XH9I11. The following intakes were investigated NC00218114, NC00222668, NC00222099, NC00219932, NC00218306, NC00214532, NC00214566, NC00214237, NC00212629, and NC00212593. 1 of the 35 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items	F 553		12/13/24

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

Electronically Signed | 12/12/2024

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F 553	Continued From page 1 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, family and staff interviews, the facility failed to offer the resident the right to participate in the person-centered planning process for 2 of 5 residents reviewed for care plans (Residents #96 and Resident #21). Findings included: 1. Resident #96 was admitted to the facility on 4/18/24 with diagnoses including heart failure, diabetes, and depression. Resident #96's most recent quarterly Minimum Data Set (MDS) assessment dated 7/22/24 indicated she was cognitively intact and required substantial to dependent assistance with most activities of daily living (ADL). Resident #96's care plans were noted as last reviewed or revised on 11/11/24. Review of Resident #96's record did not indicate	F 553	1. Resident #96 is scheduled for a care plan meeting on 12/10/24. Resident #21 is scheduled for a care plan meeting on 12/11/24. 2. All residents potentially could be affected by the deficient practice. There are 39 residents who do not have a care plan meeting scheduled in December, 2024 or January, 2025. These 39 residents will have a care plan scheduled prior to 12/13/24, and care plan meetings will be completed by 1/31/25. 3. All interdisciplinary staff members were re-educated regarding the policy and procedure for the right of residents to participate in the person centered care planning process, by the NHA, or designee on 12/10/24. This education has been added to the General Orientation of any newly hired	

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F 553	Continued From page 2 care plan meetings had been conducted. On 11/12/24 at 10:32 AM an interview was conducted with Resident #96 who deferred all questions to her Family Member. Her Family Member stated early in Resident #96's admission he had participated in a care plan meeting, but it had been a while since he was last invited or participated in a care plan meeting. He explained he would like to participate with her care planning. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated the MDS department had been short staffed and have gotten behind on care plan meetings with residents and families. After record review, she explained that only a few care plan meetings had been held in July, August and September which had not included Resident #96. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator explained the MDS department had gotten behind with conducting care plan meetings and were currently working to get caught up. 2. Resident #21 was admitted to the facility on 2/7/24 with diagnoses including cerebrovascular accident (stroke), heart failure, diabetes, and depression. Resident #21's most recent quarterly Minimum Data Set (MDS) assessment dated 10/26/24 indicated he was cognitively intact and required varying levels of assistance with his activities of daily living (ADL). Resident #21's care plans were noted as last	F 553	interdisciplinary team members. Interdisciplinary team members who do not attend the training on 12/10/24 will be required to attend the training prior to working their next scheduled shift, by the NHA, or designee. The MDS Coordinator, or designee, will audit 10 records weekly for care plan meeting notification and attendance, for 4 weeks. After 4 weeks, the MDS Coordinator, or designee, will audit 10 records per month, for 2 months, to ensure care plan meeting notification and attendance are documented. Monthly record audits for care plan meeting notification and attendance will continue after 3 months, to ensure ongoing compliance. 4. The MDS Coordinator will present the analysis of the care plan notification and attendance record audit compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction related to care plan meeting notification and attendance. 5. Completion Date: 12/13/24	

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F 553	Continued From page 3 reviewed or revised on 11/12/24. Review of Resident #21's record did not indicate care plan meetings had been conducted. An interview with Resident #21 was conducted on 11/12/24 at 2:09 PM. He stated he did not recall being invited to participate in his care planning. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated the MDS department had been short staffed and have gotten behind on care plan meetings with residents and families. After record review, she explained that only a few care plan meetings had been held in July, August and September which had not included Resident #21. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator explained the MDS department had gotten behind with conducting care plan meetings and were currently working to get caught up.	F 553		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Gradual Dose Reduction (Residents #74 and #15), Discharge Location (Resident #146), and Restraints (Resident #44) for 4 of 26 residents reviewed.	F 641	1. Residents #74 and #15 will have their MDS modified to correct coding to indicate a contraindication of a GDR of an antipsychotic medication on 12/9/24. Resident #146 will have his MDS modified to correct coding to indicate he	12/13/24

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F 641	Continued From page 4 Findings included: 1. Resident #74 was admitted on 8/20/21. His diagnoses included tactile hallucination and delusion. A psychiatry progress note dated 7/30/24 recorded Resident #74 was to continue taking quetiapine (an antipsychotic medication used to treat mental health conditions) 25 milligrams (mg) for tactile hallucination and delusion. His medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and noted a GDR was not recommended at this time. Review of Resident #74's August 2024 Medication Administration Record revealed he had received quetiapine daily. A psychiatry progress note dated 8/15/24 recorded Resident #74 was receiving quetiapine 25 mg, his medications were reviewed for possible GDR of psychotropics, and noted a GDR was not recommended at this time. Resident #74's most recent quarterly MDS assessment dated 8/19/24 indicated he had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated when completing Resident #74's 8/19/24 MDS assessment she may have only looked at the	F 641	discharged home on 10/7/24. Resident #44 will have her MDS modified to correct coding related to the absence of a restraint. All corrections will be made by the facility Case Mix Director. 2. The facility Case Mix Director, or designee, will audit 100% of all MDS□s for residents with a contraindication of GDR of an antipsychotic medication, and all restraints, by 12/10/24. The facility Case Mix Director, or designee, audited MDS within the past 3 months for discharge location; 3 MDS audited had an incorrect discharge location; these were corrected at the time of the audit. 100% of current resident MDS were audited to ensure the correct coding for GDR was documented on the MDS; 10 MDS were identified to be coded incorrectly for GDR, all 10 MDS were corrected at the time of the audit. 100% of current MDS were audited to ensure restraints were coded correctly on the MDS; all MDS audited were correct regarding restraints. All audits and corrections were made by 12/10/24. 3. All MDS licensed nurses will receive re-education related to the accuracy of assessments per the RAI manual, on 12/10/24, by the Clinical Reimbursement Consultant, RN. This education has been added to the General Orientation of any newly hired Case Mix Coordinators. Case Mix Coordinators who do not attend the training on 12/10/24 will be required to attend the training prior to working their next scheduled shift, by the Case Mix	

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F 641	Continued From page 5 scanned records and did not see the 8/15/24 psychiatry note as it had not been scanned into the medical record at that time. After further record review she stated she should have used the information from the 7/30/24 psychiatry note which indicated a GDR was contraindicated. She explained the assessment had been coded wrong. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator stated she expected MDS assessments to be accurate. 2. Resident #15 was admitted on 12/28/17. Her diagnoses included major depressive disorder and unspecified convulsions. A psychiatry note dated 8/15/24 recorded Resident #15 was receiving risperidone (an antipsychotic medication used to treat mental health conditions) 1 milligram (mg). Her medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and noted a GDR was not recommended at this time. Resident #15's October 2024 Medication Administration Record revealed she had received risperidone 1 mg twice daily and divalproex (an anticonvulsant medication used for the treatment of seizures and can also be used to treat mood disorders) 125 mg three times a day until 10/26/24 when it was reduced to twice a day. Resident #15's most recent quarterly MDS assessment dated 10/28/24 indicated she had	F 641	Director, or designee. The Case Mix Director will complete a weekly audit of five MDS□s completed by the Case Mix Coordinators. The Case Mix Coordinators will complete a weekly audit of five MDS□s completed by the Case Mix Director. All inaccuracies will be corrected at the time of review. These audits will continue weekly for twelve weeks, then monthly thereafter. The Case Mix Director will maintain a log of all identified miscodings and corrections made and track and trend the data. 4. The Case Mix Director will present the analysis of the MDS Accuracy of Assessments data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 12/13/24	

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F 641	Continued From page 6	F 641		

received antipsychotic medication routinely, did not indicate she had received anticonvulsant medication, and a GDR had been attempted on 10/23/24.

On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated another nurse had completed this assessment. She explained it appeared the nurse had considered the dose reduction of the divalproex a GDR, but this was not an antipsychotic medication. She stated the GDR had been coded incorrectly.

On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator stated she expected MDS assessments to be accurate.

3. Resident #146 was admitted to the facility on 9/23/24.

Review of the discharge Minimum Data Set (MDS) assessment dated 10/7/24 indicated Resident #146 was discharged to a short-term general hospital.

Review of a nursing note dated 10/7/24 indicated Resident #146 was discharged home with family.

An interview with the MDS Nurse on 11/14/24 at 9:45 a.m. was conducted. She stated the discharge MDS for Resident #146 dated 10/7/24 should have been coded as discharged home. She explained she had inaccurately miscoded the MDS in error.

During an interview with the Administrator on 11/15/24 at 3:04 p.m. she indicated the MDS should be completed accurately.

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F 641	Continued From page 7 4. Resident # 44 was admitted to the facility on 5/14/24 with diagnoses including Alzheimer's dementia. Resident #44's quarterly Minimum Data Set (MDS) dated 9/30/24 indicated she had severe cognitive impairment, had no behaviors, and needed supervision for ambulating around the unit. The MDS also documented that Resident #44 required a trunk restraint (a restraint on the torso that prevents a resident from getting up out of a chair) once during the observation period. Review of Resident #44's physician's orders from 7/1/24-11/14/24 did not reveal an order for a restraint. Review of Resident #44's progress notes from 7/1/24-11/14/24 did not reveal notes that she had any behaviors or any indications of a need for a restraint. The notes did not document that a restraint was used. In an interview on 11/12/24 at 12:22 PM, Nurse #4, Resident #44's regular charge nurse, said Resident #44 never had a restraint. In an interview on 11/15/24 at 1:20 PM, Nurse #5 said she completed the MDS for Resident #44. She said she could not find any documentation that the resident had a restraint. Nurse #5 indicated that she made a coding error on Resident #44's MDS when she documented that a trunk restraint was used.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		12/13/24

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F 690	Continued From page 8 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the	F 690	1. Resident #5 catheter bag will be below the level of the bladder and tubing, or any part of the drainage system will be	

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F 690	Continued From page 9	F 690		

risk of infection for 1 of 2 residents (Resident #5) reviewed with urinary catheters.

The findings included:

Resident #5 was admitted to the facility on 9/30/2024 with diagnoses that included end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), obstructive and reflux uropathy (when urine cannot drain through the urinary tract and urine backs up into the kidneys), artificial openings of urinary tract (a medical condition where a surgical procedure has created an opening in the urinary system to allow urine to exit the body when the normal pathway is blocked or damaged), and urinary tract infection (UTI).

Resident #5's care plan dated 10/3/2024 revealed focus areas for catheter care and at risk for infection. Interventions included not allowing urinary catheter bag tubing or any part of the drainage system to touch the floor, positioning the urinary catheter bag below the level of the bladder, and reporting signs/symptoms of a UTI.

An admission Minimum Data Set (MDS) assessment dated 10/4/2024 revealed Resident #5 was moderately cognitively impaired. The assessment indicated Resident #5 was dependent upon staff for all his activities of daily living (ADL). Resident #5 was coded for an indwelling catheter.

An initial observation was conducted on 11/12/2024 at 12:17 PM of Resident #5. He was observed lying in his bed. His urinary catheter

off the floor.

2. The facility currently has 12 residents who have urinary catheters. All residents catheter bags will be maintained below the level of the bladder and tubing, or any part of the drainage system will remain off the floor.

3. All licensed nurses and nursing assistants will have education related to the policy and procedure for maintaining catheters in compliance with the facility policy on 11/27/24 and 12/10/24, by the Clinical Competency Coordinator, or designee. This education has been added to the General Orientation of any newly hired licensed nurses and nursing assistants. Licensed nurses and nursing assistants who do not attend the training on 11/27/24 or 12/10/24 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.

The DHS, or designee, will monitor 12 residents weekly to ensure the catheter bag is below the level of the bladder, and tubing and all parts of the drainage system are off the floor, for four weeks. After four weeks, the DHS, or designee, will review 12 residents monthly, for the catheter bag is below the level of the bladder, and tubing and all parts of the drainage system are off the floor Monthly audits of 10 residents per month will continue, to ensure ongoing compliance.

4. The DHS will present the analysis of

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F 690	Continued From page 10 bag was hanging off the bedframe on the resident's right side of the bed, resting on the floor. An interview was conducted on 11/12/2024 at 12:21 PM with Nurse #1 assigned to care for Resident #5. When asked about the position of Resident #5's urine catheter bag, he stated "the CNA (certified nursing assistant) may have put the bed too low because of fall precautions." A subsequent observation was conducted on 11/13/2024 at 8:09 AM. Resident #5's urinary catheter bag was observed hanging off the bedframe on the resident's right side of the bed, resting on the floor. An interview was conducted with the Infection Preventionist on 11/13/2024 at 3:19 PM regarding Resident #5's urinary catheter bag observations. She stated that a urinary catheter bag resting on the floor is a concern and she would initiate re-education with staff. She further stated she would discuss this with the Clinical Competency Coordinator (Nurse Educator) so she may assist in staff re-education. An interview was conducted on 11/14/2024 2:19 PM with Nurse Aide #1 who was assigned to care for Resident #5. She stated urinary catheter bags should be kept below the bladder on the bed and off the floor. Attempts to interview the resident were unsuccessful. During an interview with the Director of Nursing (DON) on 11/14/2024 at 1:33 PM, she stated urinary catheter bags should be kept below the	F 690	the catheter audits to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 12/13/24	

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F 690	Continued From page 11 bladder, on side of bed, and should be placed off floor. She further stated all nursing staff received training regarding the care of urinary catheters in a web-based clinical competency education training system, as well as during skills fairs offered throughout the year.	F 690		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		12/13/24

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	345538	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 732	Continued From page 12 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to complete the daily staff posting sheet for 4 of 4 days observed (11/12 through 11/15/24). The daily staff posting sheet did not include the resident census of the facility. The findings included: Observation on 11/12/24 at 2:00 p.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/13/24 at 9:15 a.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/14/24 at 8:15 a.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/15/24 at 8:15 a.m. revealed the daily staffing posting at the front desk did not include the census. In an interview on 11/15/24 at 3:27 p.m., the Staffing Coordinator said she did not know how to access the census for that day, so when she came in at 5 a.m., she would make rounds and fill out the accurate information and then wait for after the meeting to put in the census on the daily	F 732	1. The facility posts the daily staffing information, including facility name, current date, number and actual hours for licensed and unlicensed nursing staff responsible for resident care per shift, and the resident census. 2. All residents have the potential to be impacted by the deficient practice. From 11/15/24 to 12/13/24, the daily staffing information has been posted 100% of the days, including the census. 3. The Nursing Home Administrator reviewed with the Staffing Coordinator the staffing expectation for posting the daily staffing information on 12/9/24. 4. The NHA, or designee, will review daily staffing posting information for four weeks. After four weeks, the NHA, or designee, will review daily staffing posting once per week for 2 months. After 3 months, weekly monitoring of the daily staffing posting information will continue, to ensure compliance. 5. The NHA will present the analysis of the daily staffing posting audit, to the QA Committee members, at the Quality	

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F 732	Continued From page 13 staffing posting. She would sometimes get busy helping residents and would forget to go back to enter the census. In an interview on 11/15/24 at 3:20 p.m., the Administrator said she was not aware the census hadn't been posted on the daily staffing posting but it should have been included.	F 732	Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 6. Completion Date: 12/13/24	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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. §483.70(h) Medical records. §483.70(h)(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(h)(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;	F 842		12/13/24

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F 842	Continued From page 14 (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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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 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(h)(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 reviews and staff interviews, the	F 842	1. Resident #399 will have her MAR and	

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F 842	Continued From page 15 facility failed to have a complete and accurate medication and treatment administration record for 1 of 7 residents (Resident #399) reviewed for medical record accuracy. The findings included: Resident #399 was admitted to the facility on 7/06/22 with diagnoses including chronic pain syndrome, high cholesterol, yeast infection of skin and nails, and non-pressure chronic ulcer of the right lower leg. Resident #399's physician orders revealed the following: - An order dated 11/02/23 for a pain evaluation every shift - An order dated 11/02/23 for atorvastatin (a statin medication used for high cholesterol) 80 milligrams (mg) one tablet at bedtime. - An order dated 11/02/23 for behavior monitoring. - An order dated 11/02/23 for miconazole nitrate (an antifungal) 2 % powder to apply twice a day to skin folds. - An order dated 11/03/23 for COVID-19 Monitoring twice a day. - An order dated 11/30/23 for oxycodone (used for pain) 5 mg one tablet twice a day. - An order dated 12/04/23 to place plastic eye shield over left eye each night at bedtime until seen by surgeon. - An order dated 12/09/23 for acetaminophen (used for pain) 325 mg two tablets twice a day. Resident #399's January 2024 Medication and Treatment Administration Record (MAR and TAR) revealed the right leg wound care, the miconazole nitrate 2% powder, the COVID-19 monitoring, the	F 842	TAR documentation accurate to reflect wound care, medications, COVID-19 monitoring, pain evaluation and behavior monitoring, and eye shield placement, as completed or refused. 2. The facility has 142 residents who have the potential to be impacted by llicensed staff documentation of accurate and complete medication and treatment, including wound care, medications, COVID-19 monitoring, pain evaluation and behavior monitoring, and eye shield shield placement. 3. All licensed nurses will have education related to the policy and procedure for completing medication and treatments as completed or refused, on 12/10/24 and 12/11/24, by the Clinical Competency Coordinator, or designee. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 12/10/24 or 12/11/24 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee. The DHS, or designee, will review 10 residents weekly to ensure documentation includes wound care, medications, COVID 19 monitoring, pain evaluation and behavior monitoring, and eye shield placement, for four weeks. After four weeks, the DHS, or designee, will review 10 residents monthly, for wound care, medications, COVID 19 monitoring, pain	

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F 842	Continued From page 16 pain evaluation, and the behavior monitoring evaluation had not been documented as completed or refused by Resident #399 for the day shift on 1/18/24. In an interview on 11/15/24 at 2:41 PM, Nurse #6 stated she worked with Resident #399 on the day shift but did not remember why she did not document on the MAR and TAR on 1/18/24. The January 2024 MAR revealed placement of the plastic eye shield, the acetaminophen, the atorvastatin, and the oxycodone had not been documented as completed or refused by Resident #399 for the night shift on 1/18/24. Attempts to interview Nurse #7, who worked with Resident #399 on the night shift on 1/18/24, were unsuccessful. The Director of Nursing (DON) and Administrator were interviewed on 11/15/24 at 3:00 PM. They were not aware there were blanks in the MARs and TARs, but said they expected documentation to be complete and accurate.	F 842	evaluation and behavior monitoring, and eye shield placement . Monthly audits of 10 residents per month will continue, to ensure ongoing compliance. 4. The DHS will present the analysis of the MAR and TAR documentation audit, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 12/13/24	