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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/03/25 through 02/06/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Q11G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 02/03/25 through 02/06/25. Event ID# Q11G11. The following intakes were investigated: NC00225172, NC00223462, NC00222514, NC00226458, NC00218941, NC00215451, NC00219516, NC 00216854, and NC00216483. 4 of the 18 allegations resulted in deficiency. The Statement of Deficiencies was amended on 2/25/25 at tag F602.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		3/6/25

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

Electronically Signed | 03/01/2025

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with staff and a family member, the facility failed to provide a clean homelike environment for 1 of 5 resident rooms on 1 of 6 halls reviewed for the environment (Room #106). The findings included: In an interview on 2/5/25 at 2:15 PM with a family member she stated there was an issue concerning the ceiling vent in resident room #106. On 2/6/25 at 8:46 AM an observation was	F 584	On 2/6/25, the Maintenance Director cleaned the black substance from around the ceiling vent in room # 106. On 2/28/25, the Maintenance Director under the oversite of the Administrator initiated an audit of the facility□s ceiling vents to include ceiling vents in all resident's rooms. This audit is to ensure all areas and rooms provide a safe, clean, comfortable and homelike environment. Work orders will be completed for all areas of concern. The audit will be	

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F 584	Continued From page 2 conducted of the ceiling vent in resident room #106. The observation revealed the outside area around the ceiling vent was in disrepair with a black colored substance on one side of ceiling vent. The surrounding area of ceiling vent, approximately 2 inches in width, had the appearance of possible water damage that had been repaired with a white spackle-like substance. An interview was conducted on 2/6/25 at 8:53 AM with the Maintenance Director. He stated vent inspections were done once or twice a month. He reviewed his electronic service logs and stated there was no work order found for the ceiling vent in resident room #106. On 2/6/25 at 8:57 AM a visual inspection was conducted with the Maintenance Director concerning the ceiling vent in resident room #106. He stated that the ceiling vent in disrepair had been overlooked. He further stated the damage appeared to be from condensation. An interview and visual inspection of the ceiling vent in resident room #106 was conducted on 2/6/25 at 9:01 AM with the Administrator. She stated it was her expectation that maintenance staff conducted inspections and made repairs when needed.	F 584	completed by 3/6/25. On 2/28/25, the Maintenance Director was in-serviced by the Administrator regarding ensuring all areas and rooms provide a safe, clean, comfortable and homelike environment. On 2/28/25 the Staff Facilitator initiated an in-service for all nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers regarding notifying Maintenance of any facility□s ceiling vents to include ceiling vents in resident's rooms in need of repair by completing a work order in TELS system. In-services will be completed by 3/6/25. After 3/6/25 any licensed nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers who have not worked will receive prior to the next scheduled work shift. All newly hired license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers will be in-serviced by the Staff Facilitator during orientation. The Maintenance Staff & Housekeeping Director will monitor all areas of the facility to include 10 resident rooms, to ensure all areas and rooms provide a safe, clean, comfortable and homelike environment weekly x 4 weeks then monthly x 1 utilizing a Homelike Environment Audit tool and completing a work order in TELS for all identified areas of concern. The Maintenance Director will immediately	

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F 584	Continued From page 3	F 584	address any identified areas of concern during the audit. The Administrator will review the Homelike Environment Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will present the findings of the Homelike Environment Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine the need for further frequency of monitoring.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, Pharmacist, and Pharmacy Consultant interviews, the facility failed to protect the resident's right to be free from misappropriation. This affected 1 of 1 resident reviewed for misappropriation of property (Resident #223). The findings included: Resident #223 was admitted to the facility on 11/7/23.	F 602	Past noncompliance: no plan of correction required.	

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Resident #223 expired on 4/13/24.

Review of the facility reported incident investigation summary completed by the Regional Consultant dated 4/29/24 revealed on 4/16/24 the Unit Manager (UM) and Assistant Director of Nursing (ADON) completed a Return of Drug form with 63 Oxycodone HCL 5 mg tablets (2 cards of 30 and 1 card of 3) along with Lorazepam, Ultram, Oxycodone HCL 2.5 mg (4 cards), Oxycodone HCL 5 mg (1 card), and Morphine Sulfate (29.0 ml). The medications were placed in a sealed bag and the controlled bag number was 1787430. The UM attempted to fax the Return of Drugs form to the pharmacy two times. The UM noticed the first time the form did not go through and therefore faxed it again but did not wait for verification. The UM returned the Return of Drugs form to the hall nurse and asked her to place it in the lock drawer with the sealed bag of medications. On 4/28/24 the UM was notified by a nurse, but did not remember the nurse's name, there was a bag of medications in the 600-hall medication cart locked narcotic drawer waiting to be returned to the pharmacy. The UM asked Nurse #2, who was on the 600-hall medication cart, for the Return of Drug form so she could fax it to the pharmacy. The UM noticed the control bag number on the Return of Drug form had been altered. She returned the Return of Drug form to the medication cart and placed it in the locked narcotic drawer with the medications. On 4/29/24 the UM asked the floor nurse for the Return of Drug form and the bag of medications. The UM and floor nurse opened the sealed bag of medications and verified that one card of Resident #223's Oxycodone HCL 5 mg which contained 30 tablets was missing. The

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controlled bag number on the Return of Drug form had been altered. The 3 was changed to 2 and the 0 was changed to 9 to match the number of 1787429 on the bag. In conclusion, the return of controlled substance policy was not followed appropriately.

Review of the Return of Drugs form dated 4/16/24 revealed the sealed control bag number of 1787430 with handwritten notes indicating the form was faxed 3 times and also a handwritten note indicating pharmacy did not pick up.

Review of a second Return of Drugs form dated 4/16/24 revealed the sealed control bag number had been altered to read 1787429.

During an interview with the Assistant Director of Nursing (ADON) on 2/6/25 at 11:25 am, she confirmed she verified the narcotic count with the Unit Manager (UM) and packed the discontinued medications which included 63 Oxycodone HCL 5 mg tablets (2 cards of 30 and 1 card of 3) along with Lorazepam, Ultram, Oxycodone HCL 2.5 mg (4 cards), Oxycodone HCL 5 mg (1 card), and Morphine Sulfate (29.0 ml) in a sealed bag on 4/16/24. The ADON stated all the medications were placed in one sealed bag which could not be re-opened. She indicated the UM returned the sealed bag of medications to the 600-hall medication cart and placed them in the locked narcotic drawer on 4/16/24. The ADON did not recall how long the medications stayed in the medication cart. She stated she remembered the medications did not go back to the pharmacy that night (4/16/24) or the next night (4/17/24).

Review of a faxed copy of the Return of Drugs form dated 4/16/24 revealed the form was faxed

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on 4/17/24 at 7:56 pm with a result of busy/no signal and faxed again on 4/17/24 at 7:57 pm with a result of busy/no signal.

In an interview on 2/6/25 at 11:41 am with the Unit Manager (UM), she stated Resident #223's discontinued medications were verified, packaged and sealed on 4/16/24 with the Assistant Director of Nursing (ADON). The UM explained she made a copy of the return of drug form and gave the copy to the Director of Nursing (DON). She further explained she returned the medications with the Return of Drug form to the locked narcotic drawer on the 600-hall medication cart. The UM indicated she faxed the return of drug form to the pharmacy once on 4/16/24 but did not verify the fax was accepted. She did not recall who faxed the return of drug form the second time. The UM stated she should have followed up on the fax to the pharmacy. On 4/28/24 the UM stated a nurse, but did not recall who brought it to her attention that medications were on the cart in the locked narcotics drawer. The UM asked Nurse #2, the nurse on the 600-hall medication cart, if there were still medications in the locked narcotic drawer. The UM stated she was unsure why the medications were still in the locked narcotic drawer. Nurse #2 brought her the Return of Drug form on 4/28/24 and she noticed that the control number on the Return of Drug form had been altered. The UM further stated she returned the Return of Drug form back to the medication cart. The UM explained she should have notified the DON at that time; however, she wanted to be sure the Return of Drug form had been altered. On 4/29/24, the UM asked the DON to pull the copy of the Return of Drug form she had given him on 4/16/24 and at that time the UM realized there was a discrepancy. The UM explained the

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medications had been removed from the control sealed bag with the number of 1787430 to a completely new sealed bag with the control number of 1787429. The Return of Drug form had been altered to match the new control number on the new bag. The UM and the DON opened the bag of medications and counted the medications. The UM and the DON verified a card of 30 Oxycodone HCL 5 mg pills were missing. The medications should have been returned to the pharmacy on 4/17/24 or 4/28/24. The DON took control of the incident at this point.

During an interview with Medication Aide (MA) #1 on 2/6/25 at 12:18 pm, she stated she was scheduled to work on 4/16/24 but could not recall if she saw a bag of sealed medications in the cart.

An interview with Medication Aide (MA) #2 on 2/6/5 at 12:24 pm, she stated the on-coming nurse or MA pulled out the resident's narcotic cards and verified the count of each narcotic. MA #2 further stated she was scheduled on 4/16/24 and remembered she saw a bag of sealed narcotics in the cart and attempted to separate each card to verify the count. She further stated it was difficult to count each card due to the number of cards in the bag and the bag could not be opened. MA #2 stated she reported this bag of medications in the cart but could not remember who she reported this to.

During a phone interview with Unit Manager (UM) #1 on 2/6/25 at 12:50 pm, she stated she did not recall an issue with narcotics left on the medication cart.

A phone interview with the Pharmacy Consultant

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on 2/6/25 at 9:51 am, she explained she did a monthly inspection at the facility which included checking the medication carts. Her medication cart review included the controlled substance count records to ensure the math and count were correct. The Pharmacy Consultant was unaware of any discrepancies in the facility for April 2024. She further stated the facility called her if any discrepancies arose.

During an interview with the Director of Nursing (DON) on 2/6/25 at 9:08 am, he stated he started in this position in March 2024. The nursing staff was scheduled for 8-hour shifts and after the incident was found the nursing shifts were changed to 12-hour shifts for better accountability of the medication carts. The facility's policy concerning controlled substances being returned to the pharmacy stated the controlled substances should be returned immediately upon discontinuation, discharge of the resident, or death of the resident. The DON stated the facility employed agency nurses and these nurses did not package medications for return to the pharmacy. The DON indicated the only way the pharmacy knew there were medications that needed to be returned to the pharmacy was the Return of Drug forms which were filled out by the nursing staff and faxed to the pharmacy. The DON stated he did not have an answer as to why he was not notified when the discrepancy was first realized on 4/28/24. His expectation was the nursing staff should have brought it to his attention on 4/28/24. The DON explained it was brought to his attention on 4/29/24 by the Unit Manager (UM). He further explained he and the UM opened the bag on 4/29/24 and verified the medications. At this time the missing card of Oxycodone 5 HCL mg was confirmed. The DON

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indicated the narcotic medications that were to be returned to the pharmacy were kept in the locked narcotic drawer on the medication carts. He also stated the nursing staff were responsible for including these narcotics in the narcotic counts at each shift change. The DON indicated he started an investigation into the missing narcotics on 4/29/24. He contacted the police department.

In an interview with the Administrator on 2/5/25 at 4:25 pm, she stated the nursing staff should be verifying the narcotic counts at the end of the shift which included any discontinued narcotics being stored in the narcotic drawer of the medication carts for pharmacy return.

The facility provided the following plan of correction (POC):

Problem: On 4/29/24 a drug diversion was identified.

o Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice include:

Resident #223 expired on 4/13/24.

o Address how the facility will identify other residents having the potential to be affected by the same deficit practice include:

On 4/29/24 the Staff Development Nurse (SDC) and Assistant Director of Nursing (ADON) completed an audit of the last 30 days of ordered narcotic medication to ensure the medications were in the cart, administered, or returned to the pharmacy per protocol.

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On 4/30/24 the Treatment Nurse initiated assessment of all residents for pain.

On 4/30/24 the Social Worker (SW) completed interviews with all alert and oriented residents regarding any concerns with medication administered to include pain medication.

o Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur include:

The police were called on 4/29/24.
A report was filed with North Carolina Department Health and Human Services (NCDHHS) on 4/29/24.
The SDC nurse initiated an in-service with all nurses and medication aides regarding Controlled Substance Diversion to include: the definition, implications, and the process for returning narcotic medications. All in-services will be completed by 4/30/24. After 4/30/24, all nurses and medication aides that have not worked and received the in-service will complete upon their next scheduled shift or via phone.

o Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Beginning 4/30/24 the Quality Improvement Nurse and/or Unit Manager will complete 5 shifts change narcotic count observations to ensure outgoing and incoming nurses perform a correct and accurate count of narcotics.

The DON will review and initial the Controlled Substance Audit Tool weekly x 4 weeks to ensure all areas of concern were addressed.

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F 602	Continued From page 11 100% of all ordered narcotic medications will be reviewed by the ADON/SDC weekly x 4 weeks and compared to the Controlled Substance Count sheets, medication administration record and/or return of drug slips to ensure the narcotic medications are being administered or have been returned to pharmacy as required per policy. The decision to take to Quality Assurance and Performance Improvement (QAPI) was made on 4/29/24. The QAPI Committee will meet monthly for 2 months and review the Audit Tools. The Regional Nurse Consultant stated she was responsible for this POC. Compliance Date: 5/1/24 On 2/6/25 the facility's corrective action plan was validated by the following: The initial audit was conducted on 4/29/24 and monitoring audits began on 4/30/24. No issues were identified. The North Carolina Department of Health and Human Services report was submitted on 4/29/24 and police were notified on 4/29/24. The Treatment Nurse completed assessments of all residents for pain on 4/30/24 and the SW completed interviews with all alert and oriented residents regarding any concerns with medication administered to include pain medication on 4/30/24. No issues were identified. Interviews and record review verified education was conducted for staff as indicated in the POC. The facility's compliance date was validated as 5/1/24.	F 602		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/6/25

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F 641	Continued From page 12 §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 code cognition and mood (Resident #58), and discharge destination (Resident #70) for 2 of 26 residents reviewed for Minimum Data Set (MDS) accuracy. The findings included: 1. Resident #58 was admitted to the facility on 12/8/23 with diagnoses that included chronic kidney disease. Resident #58's most recent annual Minimum Data Set (MDS) assessment dated 1/1/25 revealed the Mood and Cognition sections noted he was rarely/never understood and the staff assessments were not completed for these sections. During an attempted interview on 2/4/25 at 10:25 AM, Resident #58 was unable to answer questions. An interview was conducted with the facility Social Worker on 2/5/25 at 4:49 PM who stated she was responsible for conducting the cognition and mood section of the MDS assessment. She reported she was not aware a staff assessment needed to be done if the resident could not be understood. The facility Social Worker stated she had received some training from the corporate MDS consultant and had been made aware of this requirement.	F 641	On 2/5/2025, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 11/15/24 comprehensive assessment for Resident #70 to reflect accurate coding for a discharge location. On 2/5/25, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 1/1/25 comprehensive assessment for Resident #58 to reflect accurate coding of cognitive interviews. On 2/11/25, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS assessment section “A”, section “C”, and section “D” for all residents to include resident #58 and resident #70 to ensure all MDS’s assessments completed are coded accurately for discharge location and accurately completing cognitive interviews. The DON will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 3/6/25. On 2/13/25, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding	

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F 641	Continued From page 13 An interview was conducted with the Administrator on 2/6/25 at 4:10 PM who stated Resident #58's assessment should have been completed accurately. 2.Resident #70 was admitted to the facility on 11/1/24. Review of Resident #70's discharge Minimum Data Set (MDS) dated 11/15/24 revealed he was cognitively intact and was discharged to an acute hospital. Review of a progress note dated 11/15/24 documented Resident #70 was to be transported from the facility to home. During an interview with the MDS Coordinator on 2/5/25 at 12:08 pm, she explained the MDS discharge for Resident #70 dated 11/15/24 should have been coded as discharged to home and this was coded incorrectly. During an interview with the Director of Nursing (DON) on 2/6/25 at 9:24 am, he stated the residents' discharge MDS should accurately reflect the discharge status. During an interview with the Administrator on 2/6/25 at 4:00 pm, she indicated the MDS should be completed accurately.	F 641	proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for discharge status location. All newly hired MDS Coordinator or MDS nurses will be in-serviced regarding MDS Assessments and Coding during orientation. On 2/13/25, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses, MDS Coordinator, and Social Worker regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately according to the guidelines for conducting resident/staff cognition interviews for BIMS. All newly hired MDS Coordinator, MDS nurses, and Social Workers will be in-service regarding MDS Assessments and Coding during orientation. 10% audit of newly completed MDS assessments and 10% of all newly discharged completed MDS assessments, to include assessments for resident #70, and resident # 58 utilizing the MDS Accuracy Audit Tool will be reviewed by the Director of Nursing (DON) weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include discharge location and cognition status. All identified areas of concern will be addressed immediately by the Director of Nursing (DON) to include	

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F 641	Continued From page 14	F 641	retraining of the MDS nurse and completing necessary modification to the MDS assessment. The Administrator will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The Administrator will forward the results of MDS Accuracy Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, physician, and staff interviews, the facility failed to administer medications to Resident #21 as ordered when Resident #21 received the incorrect dose of Oxycodone Hydrochloride (HCL) on two occasions. This affected 1 of 1 resident reviewed for services provided meet professional standards (Resident #21). The findings included: Resident #21 was admitted to the facility on	F 658	On 2/28/25, the Unit Manager assessed resident #21 for pain. No action was necessary based upon assessment. Resident #21 current pain management is effective in managing resident's pain. On 2/28/25, the Staff Facilitator educated medication aide (MA) #1 regarding the rights of Medication Administration with emphasis on ensuring the right medication at the right dose is administered at the right time per	3/6/25

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F 658	Continued From page 15 8/5/22 with diagnoses which included osteomyelitis of vertebra (an infection of the spinal column which causes inflammation and pain), left elbow pain, and trigeminal neuralgia (a chronic pain disorder that affects the main sensory nerve in the face). A physician's order for Resident #21 dated 6/20/24, read Oxycodone HCL 10 mg to be administered one tablet every 4 hours for chronic osteomyelitis of vertebra. Review of the quarterly Minimum Data Set (MDS) dated 1/9/25 revealed Resident #21 was cognitively intact. Resident #21 was interviewed on 2/6/25 at 8:30 am and she had no concerns or complaints related to her medications. A review of the narcotic controlled substance count record for Resident #21 revealed one Oxycodone HCL 5 mg was removed on 5/17/24 at 8:00 pm by Medication Aide (MA) #1 and one Oxycodone HCL 5 mg was removed on 5/18/24 at 4:00 pm by MA #4. Review of Resident #21's May Medication Administration Record (MAR) documented Resident #21 received Oxycodone HCL 10 mg on 5/17/214 at 8:00 pm administered by MA #1 and Oxycodone HCL 10 mg on 5/18/24 at 4:00 pm administered by MA #4. In an interview on 2/6/25 at 10:00 am with MA #1 she stated she gave Resident #21 only 1 tablet of Oxycodone HCL 5 mg on 5/17/24 at 8:00 pm. The MA explained she had only administered one tablet because she was confused about the	F 658	physician order. Medication aide (MA) #4 no longer works for the facility. On 2/28/25, the Social Worker initiated resident questionnaires regarding medication concerns. The questionnaire included (1) Do you have new or worsening pain that you have not reported to the nurse (2) Do you have any concerns regarding medications to include pain medications that have not been addressed. If yes, please explain. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and/or the Treatment Nurse will address all concerns identified during the audit to include assessment of the residents, notification of the physician when indicated for further recommendations and/or education of staff. The questionnaires will be completed by 3/6/25. On 2/28/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) initiated an audit of all current resident eMARs from 2/20-2/27/25 to ensure medications to include pain medications were administered per physician order or that the physician was notified when medication was not available to administer for further recommendations. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data	

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F 658	Continued From page 16 dosage. Attempts made to interview MA #4 were unsuccessful. During an interview on 2/6/25 at 8:57 am with the Director of Nursing (DON), his expectation was the residents needed to receive the correct dosage of medications. In an interview with the Administrator on 2/5/25 at 4:25 pm, she stated her expectation was for the residents to receive the correct dose of medications.	F 658	Set Nurses (MDS) will address all concerns identified during the audit to include assessment of the resident, administering medications per physician orders when indicated, notification of the physician of any concerns identified for further recommendations and education of staff. The audit will be completed by 3/6/25. On 2/27/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) initiated Medication Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aide administered medications per the physician's order and rights of medication administration to include but not limited to the right dose at the right time. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will address all concerns identified during the audit to include assessment of the resident, administering medications per physician orders when indicated, notification of the physician of any concerns identified for further recommendations and education of staff. The audit will be completed by 3/6/25. After 3/6/25, any nurse or medication aide who has not worked or completed the medication pass audit will complete it upon the next scheduled work shift.	

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F 658	Continued From page 17	F 658	On 2/27/25, the Staff Facilitator initiated an in-service with all nurses and medication aides regarding the (1) Rights of Medication Administration with emphasis on ensuring the resident receives the right medication, at the right dose and at the right time and (2) Following Physician Orders with emphasis on how to obtain medications when not available on the cart and/or notification of the physician when medications not available for further recommendations. The in-services will be completed by 3/6/25. After 3/6/25, any nurse or medication aide who has not worked or completed the education will complete prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the SDC during orientation regarding Rights of Medication Administration and Following Physician Orders. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will complete 5 Medication Pass Audits across all shifts with nurses and medication aides weekly x4 weeks then monthly x 1 month. This audit is to ensure nurse and/or medication aide administer medication per the physician's order and rights of medication administration to include but not limited to the right dose at the right time and/or the nurse/medication aide notify the physician when medication is not available to administer for further recommendations with documentation in	

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F 658	Continued From page 18	F 658	the electronic record. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will address all concerns identified during the audit to include but not limited to assessment of the resident, administering medications per physician orders when indicated, notification of the physician of any concerns identified for further recommendations and re-training of staff. The DON will review the Medication Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator/DON will forward the results of the Medication Pass Audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		3/6/25

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F 688	Continued From page 19 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to apply a left-hand palm guard for 1 of 2 residents reviewed for a range of motion (Resident #30). The findings included: Resident #30 was admitted to the facility on 2/20/15 with diagnoses which included hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebrovascular disease affecting the left dominant side, contracture left hand, and dementia. Review of Resident #30's quarterly Minimum Data Assessment (MDS) dated 11/29/24 revealed she was moderately cognitively impaired. Resident #30 had impairments on one side of her upper and lower extremities. Records review of the nursing progress notes revealed no documentation for Resident #30's refusal to have the carrot placed in her left hand. An observation was made on 2/3/25 at 3:23 pm revealed Resident #30 lying in bed on her back and appeared to be sleeping. The resident's left hand was resting on her chest with her fingers	F 688	On 2/5/25, nursing assistant #1 applied carrot to resident #30 left hand. On 2/5/25 a therapy referral was placed by the Treatment Nurse for resident #30 to evaluate intervention for hand contractures. On 2/28/25 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and/or the Treatment Nurse initiated an audit of all residents to include resident #30 to identify any resident with contractures or risk for contractures. The audit is to ensure interventions are in place according to the plan of care. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and/or the Treatment Nurse will address all concerns identified during the audit to include placing interventions per plan of care, initiating a therapy referral when indicated, updating the care plan for new interventions, notification of the provider or resident representative of care refusals and/or education of staff. Audit will be completed by 3/6/25.	

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F 688	Continued From page 20 balled into a fist. This surveyor observed a piece of paper taped to the wall at the end of Resident #30's bed dated 9/2/24 by physical therapy which read in part "Attn Staff: Keep carrot in left hand except during bathing." A second observation was made on 2/4/25 at 9:12 am revealed Resident #30 sitting up in her bed awake and when asked if she could open her left-hand Resident #30 tried but the left hand stayed closed. In an interview and observation with Nurse #1 on 2/5/25 at 8:22 am of Resident #30, she indicated Resident #30 was supposed to have a carrot in her left hand to protect the skin from moisture, pressure and nail puncture injuries. When asked where the carrot was, Nurse #1 presented the carrot from a basket located on Resident #30's bedside table. Nurse #1 stated Resident #30 would refuse at times to have the carrot placed in her left hand. During a subsequent observation on 2/5/25 at 10:20 am revealed Resident #30 sitting up in her bed awake. Resident #30's left hand was on her chest under the sheet. This surveyor asked Resident #30 could the cover sheet be pulled back to see her left hand and Resident #30 answered yes. Resident #30's left hand was empty. The carrot was still located in the basket on the bedside table. In an interview and observation with NA #1 on 2/5/25 at 11:00 am, she stated Resident #30 was resistive to care. NA #1 further stated she would make the nurse aware of her refusals. NA #1 explained to Resident #30 that she was putting the carrot in her left hand and Resident #30	F 688	On 2/28/25, the Staff Facilitator initiated staff questionnaires with all nurses and nursing assistants regarding residents with contractures or at risk for contractures to include: (1) Do you know of any resident who has a decrease/decline in mobility or contractures? (2) If yes, who and who did you report it too? (3) Do you know of any resident who refuses to wear splints, palm protectors or other devices to prevent new or worsening contractures? (4) If yes, who and who did you report it too? The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will address all areas of concern to include initiating a therapy referral when indicated, updating the care plan for new interventions, or notification of the provider or resident representative of care refusals. Questionnaires will be completed by 3/6/25. After 3/6/25, any nurse or nursing assistant who has not worked or received the in-service will complete it upon the next scheduled work shift. On 2/28/25 an in-service was initiated by the Staff Facilitator with all nurses, and nursing assistants in regards to Residents with Contractures or At Risk for Contractures with emphasis on (1) initiating therapy referral for any resident with contractures/at risk for contractures or decline in mobility of extremities when indicated (2) ensuring interventions to prevent new or worsening contractures are in place per plan of care/physician orders and (3) notification of the	

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F 688	Continued From page 21 shook her head and responded verbally yes. NA #1 proceeded to put the carrot in Resident #30's left hand while talking to Resident #30. NA #1 finished placing the carrot in Resident #30's left hand and asked Resident #30 was she okay. Resident #30 responded yes. In an interview with the Physical Therapy (PT) Director on 2/5/25 at 10:18 am, he explained Resident #30 had been seen by therapy since her admission. The PT Director further explained the nursing staff would make referrals for Resident #30 for therapy services and Resident #30 would be picked up on caseload. The therapy department would evaluate and work with Resident #30. The PT Director explained a physician's order was not needed for the carrot. The PT Director stated Resident #30 was to have the carrot placed in her left hand except during bathing. He further stated he had in-serviced the nursing staff on how to place the carrot in Resident #30's left hand. The PT Director further stated Resident #30 could be resistive to care at times. During an interview with the Director of Nursing (DON) on 2/5/25 at 10:25 am, he stated he was unaware of Resident #30's situation with the left-hand palm guard. The DON further stated he would investigate this concern. The DON indicated the nursing staff should have attempted to place the carrot in her left hand and if Resident #30 refused, the nursing staff should have documented the refusals.	F 688	provider/therapy when the resident refuses interventions for additional recommendations with documentation in the electronic record and (4) notification of the resident representative of refusals. In-service will be completed by 3/6/25. After 3/6/25 any nurse or nursing assistant who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator regarding Residents with Contractures or At Risk for contractures. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and/or the Treatment Nurse will complete 5 audits of residents with contractures or at risk for contractures weekly x 4 weeks the monthly x 1 month utilizing the Splint Audit Tool. This audit is to ensure that interventions are in place to prevent new or worsening contractures, staff apply splints/palm protectors or other devices per plan of care/physician orders or notify the nurse of care refusals with documentation in the electronic record. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and/or the Treatment Nurse will address all concerns identified during the audit to include placing interventions per plan of care, initiating a therapy referral when indicated, updating the care plan for new interventions, notification of the provider or resident representative of care refusals and/or re-training of staff. The DON will review the Splint Audit Tool	

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F 688	Continued From page 22	F 688	weekly for 4 weeks, then monthly x one month to ensure all areas of concern were addressed. The Administrator will forward the results of the Splint Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen (O2) was in use for 1 of 6 residents reviewed for respiratory care (Resident #174). The findings included: Resident #174 was admitted to the facility on 1/13/25 and was readmitted on 2/1/25. Resident #174's diagnoses included acute respiratory	F 695	On 2/6/25, the Assistant Director of Nursing (ADON) verbally educated nurse #8 regarding posting oxygen in use signage on the door for any resident receiving supplement oxygen. The nurse verbalized understanding of education. On 2/5/25, the Central Supply Clerk placed a cautionary signage on resident #174 door identifying the resident utilizing supplemental oxygen per facility protocol.	3/6/25

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AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL ROAD AYDEN, NC 28513

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F 695	Continued From page 23 failure with hypoxia (a medical condition where the lungs are unable to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood) and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). Review of Resident #174's physician's orders revealed she had an oxygen order dated 2/2/25 for oxygen supplementation at 2L (liters) via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) or mask if oxygen saturation (the amount of oxygen you have circulating in your blood) is less than 90%. Resident #174's Admission Minimum Data Set dated 1/19/25 revealed she was cognitively intact. Observations on 2/3/25 at 12:14 PM, 2/4/25 at 9:01 AM, and 2/5/25 at 5:41 AM revealed Resident #174 was in her room, lying in bed, wearing a nasal cannula for supplemental oxygen. There was no signage outside Resident #174's room indicating supplemental oxygen was in use. An interview was conducted on 2/5/25 at 5:44 AM with Nurse #8 who stated residents who received oxygen should have an oxygen sign on their door. She further stated the oxygen sign was put on the door upon a resident's admission. An interview was conducted on 2/5/25 at 10:11 AM with Unit Manager #1. She stated staff were supposed to put an oxygen sign on a resident's door immediately when admitted. An interview was conducted on 2/5/25 at 8:18 AM with the Director of Nursing (DON). He stated a sign was placed on a resident's door for any	F 695	On 2/28/25, the Central Supply Clerk initiated an audit of all residents with orders for supplemental oxygen. This audit is to ensure appropriate cautionary signage is placed on the resident door indicating supplemental oxygen in use. The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will address all concerns identified during the audit to include posting cautionary signage when indicated and education of the staff. The audit will be completed by 3/6/25. On 2/28/25, the Staff Facilitator initiated an in-service with all nurses, nursing assistants and Centra Supply Clerk regarding Oxygen with emphasis on ensuring a cautionary signage is posted on the room door for any resident utilizing supplemental oxygen. In-services will be completed by 3/6/25. After 3/6/25 any nurse, nursing assistant or supply clerk who has not worked or completed the in-service will complete it at the next scheduled shift. All newly hired nurses, nursing assistants or Central Supply Clerks will be educated during orientation by the Staff Facilitator. The Central Supply Clerk will audit all residents utilizing supplemental oxygen weekly x 4 weeks then monthly x 1 month utilizing Oxygen Signage Audit Tool. This audit is to ensure cautionary signage is posted at the resident room door to identify residents receiving supplemental oxygen. The Director of Nursing (DON) will address all concerns identified during	

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F 695	Continued From page 24 resident on oxygen upon admission and for any resident who experienced a change in condition requiring new oxygen therapy. He further indicated that an oxygen sign should have been placed on Resident #174's door.	F 695	the audit to include posting signage when indicated and re-training of staff. The Director of Nursing (DON) will review the Oxygen Signage Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Oxygen Signage Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and 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	F 761		3/6/25

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F 761	Continued From page 25 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure residents' medications in a locked medication cart for 1 of 4 medication carts observed (Station 1 medication cart). Findings included: A continous observation was conducted on 2/5/25 from 6:47 am until 6:52 am of the Station 1 medication cart. The medication cart was observed unlocked and located outside the nurse's station in the hallway. There were no medications observed on top of the medication cart. There was no nurse observed at Station 1 medication cart or in the nursing station. There were no residents in the hallway, but staff was observed on the adjacent 100-hall coming in and out of the residents' rooms. On 2/5/25 at 6:52 am, Nurse #7 was observed walking down the 100-hall towards the unlocked Station 1 medication cart. Nurse #7 observed this surveyor standing beside Station 1 medication cart and locked the medication cart. On 2/5/25 at 6:52 am during an interview with Nurse #7, she was observed locking Station 1 medication cart. She stated she had left her cart unlocked. Nurse #7 further stated the medication cart was to be locked before leaving the medication cart unattended. When asked why	F 761	On 2/28/25, the Assistant Director of Nursing (ADON) educated nurse #7 regarding medication storage with emphasis on ensuring the medication cart is locked when not under direct supervision of the nurse. The nurse verbalized understanding of the education. On 2/7/25, the Director of Nursing (DON) validated the medication cart on station one was locked when not under the direct supervision of the nurse. On 2/28/25, the Administrator initiated an audit of all medication carts to include the medication cart on station one. The audit is to ensure medication carts are locked when not under the direct supervision of the nurse and/or medication aide (MA). The Administrator will address all concerns identified during the audit to include securing/locking the medication cart when indicated and education of staff. The audit will be completed by 3/6/25. On 2/28/25, the Staff Facilitator initiated an in-service with all nurses and medication aides to include nurse # 7, regarding Medication Storage with emphasis on storage of	

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F 761	Continued From page 26 Station 1 medication cart was observed unattended and unlocked, Nurse #7 did not provide a reason. In an interview with the Director of Nursing (DON) on 2/6/25 at 9:24 am, he stated Sation 1 medication cart was to be locked at all times when the nurse was not present at the medication cart.	F 761	medication/securing medication cart when not directly supervised by assigned nurse/MA. In-service will be completed by 3/6/25. After 3/6/25 any nurse or medication aide who has not worked or received the education will receive it upon the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation regarding Medication Storage. An audit of all medication carts will be monitored by the Administrator twice weekly x 4 weeks then monthly x 1 month to include all shifts utilizing the Medication Cart Audit Tool. This audit is to ensure medications are secured per the facility protocol and that all carts are locked when not under the direct supervision of the nurse/MA. The Administrator will address all concerns identified during the audit to include securing/locking the medication cart when indicated and re-training of staff. The Director of Nursing will review the Medication Cart Audit Tool for completion and to ensure all areas of concerns are addressed twice weekly x 4 weeks then monthly x 1 month. The Director of Nursing will forward the results of the Medication Cart Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 2 months to review, address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring.	
F 842 SS=B	Resident Records - Identifiable Information	F 842		3/6/25

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F 842	Continued From page 27 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; (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	F 842		

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F 842	Continued From page 28 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 review, staff interviews, the facility failed to ensure the medical record was accurate regarding administration of Oxycodone Hydrochloride (HCL) (an opioid medication which is a controlled substance) for 1 of 1 resident (Resident #21) reviewed for accuracy of medical records. The findings included:	F 842	On 2/28/25, the Staff Facilitator educated medication aide (MA) #1 regarding the rights of Medication Administration with emphasis on ensuring the right medication at the right dose is administered at the right time per physician order with documentation in the electronic record. Medication aide (MA) #4 no longer works for the facility.	

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F 842	Continued From page 29 Resident #21 was admitted to the facility on 8/5/22 with diagnoses which included osteomyelitis of vertebra (an infection of the spinal column which causes inflammation and pain), left elbow pain, and trigeminal neuralgia (a chronic pain disorder that affects the main sensory nerve in the face). A physician's order for Resident #21 dated 6/20/24, read Oxycodone HCL 10 mg to be administered 1 tablet every 4 hours for chronic osteomyelitis of vertebra. A review of the narcotic controlled substance count record for Resident #21 revealed one Oxycodone HCL 5 mg on 5/17/24 at 8:00 pm was signed out by Medication Aide (MA) #1 and one Oxycodone HCL 5 mg on 5/18/24 at 4:00 pm MA #4. Review of Resident #21's May Medication Administration Record (MAR) revealed documentation the resident received Oxycodone HCL 10 mg on 5/17/214 at 8:00 pm administered by MA #1 and Oxycodone HCL 10 mg on 5/18/24 at 4:00 pm administered by MA #4. In an interview on 2/6/25 at 10:00 am with MA #1 she stated she gave Resident #21 only 1 tablet of Oxycodone HCL 5 mg on 5/17/24 at 8:00 pm. Attempts made to interview MA #4 were unsuccessful. During an interview on 2/6/25 at 8:57 am with the Director of Nursing (DON), his expectation was the residents' medical records needed to reflect the correct dosage of administered medications.	F 842	On 2/28/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) initiated an audit of all current resident eMARs from 2/20-2/27/25 to ensure medications to include pain medications were administered per physician order with documentation in the electronic medication administration record (eMAR) or that the physician was notified when medication was not available to administer for further recommendations. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will address all concerns identified during the audit to include assessment of the resident, administering medications per physician orders when indicated, notification of the physician of any concerns identified for further recommendations and education of staff. The audit will be completed by 3/6/25. On 2/27/25, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) initiated Medication Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aide administered medications per the physician’s order and rights of medication administration to include but not limited to	

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F 842	Continued From page 30 In an interview with the Administrator on 2/5/25 at 4:25 pm, she stated her expectation was for the residents' medical records to be accurate and reflect the correct dosage of medications when they were administered.	F 842	the right dose at the right time with documentation on the. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will address all concerns identified during the audit to include assessment of the resident, administering medications per physician orders when indicated, notification of the physician of any concerns identified for further recommendations and education of staff. The audit will be completed by 3/6/25. After 3/6/25, any nurse or medication aide who has not worked or completed the medication pass audit will complete it upon the next scheduled work shift. On 2/28/25, the Staff Facilitator initiated an in-service with all nurses and medication aides regarding the Rights of Medication Administration with emphasis on (1) ensuring the resident receives the right medication, at the right dose and at the right time with documentation on the eMAR and (2) completing three checks when administering medications to ensure appropriate medication/dose is administered per physician orders. The in-services will be completed by 3/6/25. After 3/6/25, any nurse or medication aide who has not worked or completed the education will complete prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the SDC during orientation regarding Rights of Medication Administration.	

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F 842	Continued From page 31	F 842	The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will complete 10 Medication Pass Audits across all shifts with nurses and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure nurse and/or medication aide administer medication per the physician's order and rights of medication administration to include but not limited to the right dose at the right time and the nurse/MA completed a three-check process prior to administering medications to ensure the right medication, right dose is provided to the right resident. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), the Treatment Nurse and/or Minimum Data Set Nurses (MDS) will immediately re-train any nurse or MA for all concerns identified. The DON will review the Medication Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator/DON will forward the results of the Medication Pass Audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	