STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 04/04/2025

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		5/1/25

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

Electronically Signed | 05/01/2025

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) plan which contained the required information to meet the health, safety, and security needs of the residents and staff. This had the potential to affect all facility residents. The findings included: A review of the facility's Emergency Preparedness plan on 4/3/25 revealed: A. The Director of Nursing reviewed the EP plan on 3/28/25, but all of the sections were not updated. B. The EP plan did not include updated contact information for facility staff, physicians, or other long-term care facilities. C. The EP plan did not include updated contact information for emergency Federal and State agencies including the Office of the Long-Term Care Ombudsman. D. The EP plan did not include documentation of the annual training or required exercises for staff on the EP plan. The Administrator was interviewed on 4/3/25 at 3:49 PM and stated that although the last review	E 001	Corrective action for the residents found to be affected by the deficient practice. No residents were identified in the 2567. Corrective Action for other residents having the potential to be affected by the same deficient practice. On 4/24/25 the Licensed Nursing Home Administrator and Director of Health Services reviewed all residents that would be involved or affected in the emergency preparedness plan. Systemic changes made to ensure that the deficient practice will not recur. On 4/29/2025 the Senior Nurse Consultant educated the Administrator regarding the updating the emergency management plan policy and procedures to include the updating of the employee roster, completion of training upon hire and annually for all employees, and mandatory internal and external training exercises for staff. All staff will be educated by the Administrator and/or Department manager regarding the emergency manual requirements by 4/30/25, employees not educated will be educated prior to their next scheduled	

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E 001	Continued From page 2 date was documented on 3/28/25 by the Director of Nursing, only some sections of the EP plan had been updated but not all. Review of the EP book revealed there was no system in place to ensure all staff and new hires were trained upon hire or annually. The Administrator stated that the updated contact forms for the facility and Federal/State agencies were not placed in the EP binder since the last recertification survey in January 2024. She further stated that the EP binder should always be up to date. The Administrator revealed that updating the EP binder was ultimately her responsibility; however, she stated she did not have enough support staff to assist her including the Maintenance Director and there had been turnover with other support positions as well.	E 001	shift or removed from the schedule. This education has been added to the general orientation of all newly hired employees. The Licensed Nursing Home Administrator and / or Director of Health Services will review the Emergency Preparedness Plan required weekly for four weeks to validate and provide newly acquired directors/ employees to the contact sheet and any policy/ procedure updates. This review is completed weekly times for four weeks, then monthly thereafter until three months of sustained compliance is maintained then quarterly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The licensed Nursing Home Administrator will present the analysis of the Emergency Preparedness Plan to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: 5/1/2025	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/31/25 through 04/04/25. Event ID# 8LHS11. The following intakes were investigated: NC00218332, NC00219741, NC00223700,	F 000		

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F 000	Continued From page 3 NC00224184, NC00224196, NC00224456, NC00224760, NC00227420, NC00228296, and NC00228608. 1 of the 25 complaint allegations resulted in deficiency.	F 000		
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 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, records review, and resident and staff interviews, the facility failed to apply a left-hand splint for 1 of 3 residents (Resident #31) reviewed for contractures. Findings included: Resident #31 was admitted to the facility on 10/16/24 with diagnoses that included hemiplegia	F 688	Corrective action for the residents found to be affected by the deficient practice. Resident # 31 was evaluated on 4/3/25 by occupational therapy for hand splinting. Corrective action for other residents having the potential to be affected by the same deficient practice.	5/1/25

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F 688	Continued From page 4 and hemiparesis following cerebral infarction affecting left non-dominant side, contractures of muscle (multiple site), altered mental status, diabetes mellitus type2, and congestive heart failure. Review of the physician orders dated 10/17/24 indicated Occupational Therapy (OT) to be provided 5 times per week for 8 weeks and treat diagnoses of left hemiplegia, contractures, reduced mobility, impaired coordination, and general weakness. This order was discontinued on 12/5/24. Review of the OT discharge summary dated 12/5/24 indicated Resident #31 received OT services from 10/17/24 to 12/5/24. The resident at discharge was able to tolerate left upper extremity wrist/hand orthosis (external devices to correct alignment or provide support) up to 5 hours with no adverse side effects. Discharge recommendations included recommending continuation of orthosis application up to 6 hours continuous duration of wear every day, with regular skin checks and pain monitoring. Review of the quarterly Minimum Data Set (MDS) assessment date 1/23/25, revealed Resident #31 was assessed as moderately impaired cognition, with no behaviors exhibited. Assessment indicated the resident had impaired range of motion on one side to upper extremities. The resident required substantial/maximal assistance from staff for most of her activities of daily living (ADL) Care. During an observation and interview on 3/31/25 at 10:40 AM, Resident #31 was observed lying in her bed. She had contractures to her left hand	F 688	On 4/25/25 the Director of Health Services and/or Nurse managers reviewed all residents with splinting devices to validate compliance with donning and doffing appliance. All residents noted with appropriate splinting devices and/or received referrals to occupational therapy. Systemic changes made to ensure that the deficient practice will not recur. On 4/25/25 the Director of Health Services and/or Nurse managers began education to all nursing staff regarding donning and doffing splint□s and referring residents with decline to the therapy department for an evaluation. Nursing staff who are not educated by 4/29/25 will be educated prior to their next scheduled shift and/or removed from the schedule. This education has been added to the general orientation of all newly hired nursing employees. The Director of Health Services and/or Nurse Managers review each resident requiring splinting daily for seven days then weekly for four weeks to validate that the splinting is in place and any residents with decline have been referred to the therapy department for an evaluation. This review is completed daily for seven days, then weekly for four weeks, then monthly thereafter until three months of sustained compliance is maintained then quarterly thereafter.	

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F 688	Continued From page 5 and was not observed to be wearing any splint. The resident's finger tips were not in contact with her palm. During an interview Resident #31 indicated she does not go to therapy and no splints were placed on her left hand. During an observation on 4/2/25 at 11:53 AM, Resident #31 was observed sitting in the Geri chair in her room. The resident did not have a splint applied to her left hand that had contractures. During an interview on 4/2/25 at 11:55 AM, Nurse Aide #2 indicated she was frequently assigned to the resident. Nurse aide stated Resident #31 had contractures to her left hand but has never seen any splints applied to her left hand. Nurse Aide indicated splints were applied by nurses assigned to the resident. During an interview on 04/02/25 12:07 PM, Nurse #5 stated she was frequently assigned to the resident. Nurse #5 indicated Resident #31 had contractures to her left hand, however, there were no orders from therapy or no splint available to be placed on the resident's palm. She indicated she does not recollect any orders or education provided by therapy for the splint. During an interview on 04/03/25 11:16 AM, Nurse #4 indicated she was one of the unit managers for the floor. Nurse #4 stated Therapy staff would notify the nurses when they have any recommendations/orders for splint application. These orders were entered into matrix care (electronic health record) and the nursing staff continued to put the splint as per therapy orders. Nurse #4 stated there was no in-service or order sheet for nursing staff acknowledging that the	F 688	Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will present the analysis of the splinting and therapy referral review to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: 5/1/2025	

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F 688	Continued From page 6	F 688		

orders were notified, and staff were trained. Nurse #4 stated Resident #31 had contractures to her left hand and was under therapy. However, there were no orders from therapy and there were no splints provided for the staff.

During an observation and interview on 4/3/25 at 11:09 AM, the Rehab Director stated based on the OT discharged summary, Resident #31 was discharged with a splint from OT services. The Rehab Director searched the resident's room for splints. An empty mesh bag that was used for splint storage was found in the resident's closet. The Rehab Director indicated she was unable to find Resident #31's splints in her room. The Rehab Director stated that when any resident was discharged from therapy with splints, the nurses would be made aware of the splints and how long they should be worn. If training was needed, then it would be provided for staff. The nurse would then document the information in the resident's record and splints would be applied accordingly. The Rehab Director further stated Resident #31 was discharged from OT on 12/5/24 with recommendations for splint application for 6 hours daily. She indicated the therapy staff would reevaluate the resident and access/treated for new splints.

The Rehab Director was reinterviewed on 4/3/25 at 11:34 AM. The Rehab Director indicated the Occupational Therapist who had worked with Resident #31 was no longer employed at the facility. She further stated that she was unsure where the in-service documentation or order documentation were placed. She was also unsure if nurses were notified about the splints.

The occupational therapist was unavailable for an

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F 688	Continued From page 7 interview. During an interview on 4/3/25 at 12:18 PM, the Administrator stated there must be a breakdown in communication between the OT and nurses, resulting in the splint not been placed. She further stated that a better process needed to be implemented to ensure splints were placed on residents who needed them. Administrator indicated Resident #31 was re-evaluated by the therapy staff and would be treated with new splints.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		5/1/25

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F 693	Continued From page 8 by: Based on observations, record review, and staff interviews, the facility failed to label and shake a new tube feeding formula bottle before hanging for 1 of 3 residents (Resident #307). The findings included: Review of the facility's "Enteral Feeding: Using a Pump" instructions for nurses dated 2022 read in part: "Shake the container of formula to ensure that it is mixed well ...Label the bag or container with the type of formula, strength, amount, and rate of administration as well as the date, time, and your initials." Resident #307 was admitted to the facility on 11/25/24 with diagnoses which included stroke, dysphagia, and gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage). Review of Resident #307's quarterly Minimum Data Set (MDS) assessment dated 3/4/25 revealed he was severely cognitively impaired and required substantial/maximal assistance with most activities of daily living (ADL). Resident #307 received all nutrition and hydration through the feeding tube. Review of Resident #307's care plan dated 12/5/24 revealed he received tube feedings related to the risk for aspiration. Interventions included: Elevate head of bed per protocol. Replace the feeding tube as ordered. Monitor feeding tube site for signs/symptoms of infection and inform the provider of any changes. Treatment to feeding tube site as ordered.	F 693	Corrective action for the residents found to be affected by the deficient practice. The tube feeding bag/bottle was changed by the nurse when identified, ensuring the new bottle was was shaken prior to use and labeled the bottle with resident□s name, date, time and rate. Corrective action for other residents having the potential to be affected by the same deficient practice. On 4/25/25 all tube feeding bags were reviewed to ensure the bag was labeled with the resident name, date, time hung and rate. No other residents were affected by this practice. Systemic changes made to ensure that the deficient practice will not recur. On 4/25/25 The Director of Health Services and Nurse managers began education to all Nurses related to shaking the tube feeding bottle prior to hanging and labelling the bottle with the resident□s name, date, time hung and rate. Any nurse not educated by 4/29/2025 will be educated prior to their next scheduled shift or removed from the schedule. This education has been added to the general orientation of all newly hired nurses. The Director of Health Services and/or Nurse managers will observe three tube feeding bottles being hung by the nurses for proper shaking of the bottle prior to	

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F 693	Continued From page 9 Administer medications via feeding tube per the orders and policy. Verify placement of the feeding tube by auscultation. Flush feeding tube as ordered. Notify provider of any problems. Labs as ordered. Administer tube feeding as ordered. Review of a physician order dated 2/11/25 revealed an order for Resident #307 to receive Glucerna 1.5 at 73 milliliters (ml) per hour (hr) administered continuously over 24 hours with all shifts required to document in the medication administration record (MAR). An observation of Resident #307's tube feeding formula bottle was conducted on 3/31/25 at 12:16 PM. There were no date/time/initials on the tube feeding bottle, and there was sediment stuck at the top of the bottle, which was almost empty. An observation and interview with the day shift Nurse #7 were conducted on 3/31/25 at 12:19 PM. She stated Resident #307's tube feeding bottle was already hanging when she started her shift at 7:00 AM. Nurse #7 indicated that the tube feeding bottle should be signed and dated when hung. The sediment observed at the top of the feeding bottle was most likely related to it not being shaken. Nurse #7 stated that she received shift change report from the overnight Nurse #10 and nothing was mentioned about the tube feeding bottle. Review of the Marh 2025 MAR revealed that Nurse #11 signed off Resident #307 received his enteral tube feeding during the day and evening shifts, and Nurse #10 signed off during the evening shift. Nurse #10 was interviewed on 4/02/25 at 9:16	F 693	hanging, and labeling of the bottle with resident□s name, date, time and rate, weekly for four weeks then every other week for four weeks, then monthly thereafter until three months of sustained compliance in maintained then quarterly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will present the analysis of the tube feeding review to the Quality Assurance and Performance Improvement committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: May 1, 2025	

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F 693	Continued From page 10	F 693		

AM. She revealed that she did work with Resident #307 from 7:00 PM - 11:00 PM on 3/30/25 and then was reassigned to another floor from 11:00 PM on 3/30/25 until 7:00 AM on 3/31/25. Nurse #10 stated that her normal process when changing the tube feeding bottle was to label, date, time, and initial the new bottle. Just because she signed off on the MAR during the overnight shift on 3/30/25 did not mean that she hung a new bottle but rather confirmed that the tube feeding was running as ordered. She could not recall if she hung a new bottle or not for Resident #307 on 3/30/25 night shift. She could only recall hanging a new bottle for another resident. Nurse #10 indicated the day shift nurse (Nurse #11) must have hung the tube feeding bottle for Resident #307 because each bottle lasted almost 14 hours.

An interview was conducted with Nurse #11 on 4/03/25 at 9:29 AM. She stated when hanging a new tube feeding bottle, the patient's name, room number, date, time of hanging, and her initials needed to be labeled on the new bottle. Nurse #11 indicated that she had never shaken the tube feeding bottle before hanging. She changed the tube feeding bottle at the end of the shift around 7:00 PM for Resident #307 on 3/30/25. Nurse #11 stated that she was in a hurry to leave the facility and forgot to label the new bottle properly.

During an interview with the Director of Healthcare Services on 4/03/25 at 10:52 AM, she revealed that Resident #307's tube feeding bottle should have been shaken and labeled with the date and time of hanging, as well as Nurse #11's initials when it was hung on 3/30/25.

The Administrator was interviewed on 4/03/25 at

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F 693	Continued From page 11 10:55 AM. She revealed that Resident #307's tube feeding formula bottle should have been shaken before hanging. After hanging, the bottle should have been labeled with the date and time of the hanging as well as Nurse #11's initials.	F 693		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on posted daily staffing data and daily staffing schedules and staff interviews, the facility failed to have a nurse available resulting in the Director of Healthcare Services (commonly referred to as the Director of Nursing (DON)) working on the medication cart, when the facility's daily average census was between 105 -106 residents. This was noted for 2 of 31 (3/21/25 and 3/30/25) days reviewed for staffing. Findings included: The posted daily staffing data and staff schedules were reviewed from 3/1/25 to 3/31/25.	F 727	Corrective action for the residents found to be affected by the deficient practice. No residents were identified in 2567. The Director of Health Services is not placed on the active schedule to push a medication cart. The facility has hired two nurses and is actively recruiting more Licensed and Registered Nurses. Corrective action for other residents having the potential to be affected by the same deficient practice.	5/1/25

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F 727	Continued From page 12 Review of the posted daily staffing data for 3/21/25 revealed the facility had a census of 106 residents. Review of the staffing schedule for 3/21/25 revealed the RN who was scheduled to work 3:00 PM to 11:00 PM shift had called out. The DON, who was an RN, was working on the medication cart for 4 hours, until she was replaced by another nurse. The DON was assigned to cart on 2nd floor (short hall) from 3:00 PM to 7:00 PM. Review of the posted daily staffing data for 3/30/25 revealed the facility census was 105 residents. Review of the staffing schedule for 3/30/25 revealed the RN who was scheduled to work 3:00 PM to 11:00 PM shift had called out. The DON was assigned to a medication cart on 2nd floor (long hall) from 7:00 PM to 11:00 PM. During an interview on 4/1/25 at 1:49 PM, the Scheduler stated that on 3/21/25 there was a call out and no nurse was available to fill the slot or work on the medication cart. The DON was on the cart for 4 hours. The Scheduler stated the facility was able to find a nurse to replace the DON later that evening. The Scheduler further stated she was not aware the DON was working over the weekend on 3/30/25. She indicated that she became aware of it on Monday (3/31/25) morning. The Scheduler stated this was the first month the DON had to work on the medication carts and be assigned a floor. During an interview on 4/2/24 at 2:25 PM, the DON stated it was a last-minute situation as the nurse assigned to the cart had a family emergency. Calls were made for other nurses	F 727	All residents have the potential to be affected. Systemic changes made to ensure that the deficient practice will not recur. On 4/25/25 the Nursing Scheduler has been educated by the Administrator that the Director of Health Services can only be the last resort in an emergency to assist with medication pass within the facility. This education has been added to the general orientation of all newly hired nursing schedulers. The Nursing scheduler will reach out to the other Nurses including nurse managers, in the facility to assist in running the medication cart when a call in occurs. When no Nurse is available to work the medication cart, the Nurse Scheduler will contact the Director of Health Services and Administrator for their assistance in obtaining a nurse to cover the shift. AS the facility is over 60 beds, the Director of Health Services is never assigned on the schedule to push a medication cart. The facility administrator will review the daily staffing sheets seven days in advance of the schedule to ensure the Director of Health Services is not scheduled to work a medication cart. This will be completed weekly by the Administrator for eight weeks and then monthly thereafter until three months of sustained compliance is maintained, then quarterly thereafter.	

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F 727	Continued From page 13 from the nursing pool and unfortunately the slot on both days could not be filled for few hours. The DON indicated she had to be assigned to a cart on the floor. During an interview on 4/4/25 at 11:41 AM, the Administrator stated the DON does not work on the medication carts on the floor, however on 2 days during the past month, the facility was unable to fill the nurse slot for few hours when the assigned nurse had an emergency call out. Hence the DON was working on the medication cart. The Administrator indicated the facility was hiring nursing staff and few nurses were in the process of been hired.	F 727	Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will present the analysis of the Director of Nursing working a medication cart to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: 5/1/2025	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, resident, and the Pharmacist, the facility failed to administer medications as ordered for 1 of 6 residents (Resident #64). Staff did not remove medication from the refrigerator believing the medication had not been received by the pharmacy, resulting in 11 missed doses of eyedrops for glaucoma. Findings included: Resident #64 was admitted to the facility on 9/13/2022 with diagnoses including glaucoma. A physician's order dated 1/04/2025 noted	F 760	Corrective action for the residents found to be affected by the deficient practice. On 4/2/25 the Director of Health Service reviewed Resident # 64 medication administration records to validate the eye drops were given as prescribed from 3/20/25 through 4/2/25. Corrective action for other residents having the potential to be affected by the same deficient practice. On 4/25/25 the Director of Health Services and Nurse Managers reviewed	5/1/25

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F 760	Continued From page 14 Resident #64 was to receive timolol maleate 0.5 % eyedrops twice a day for glaucoma. Resident #64's February 2025 Medication Administration Record (MAR) noted she did not receive her timolol maleate eyedrops on 2/01/2025 at 9:00 AM, 2/01/2025 at 5:00 PM, 2/11/2025 at 5:00 PM, 2/12/2025 at 5:00 PM, 2/13/2025 9:00 AM, and on 2/14/2025 at 9:00 AM. The reasons noted by nursing staff were that the medication was unavailable, and they were awaiting delivery from the pharmacy. Resident #64's March 2025 MAR noted she did not receive her timolol maleate eyedrops on 3/01/2025 at 9:00 AM, 3/01/2025 at 5:00 PM, 3/17/2025 at 5:00 PM, 3/19/2025 at 9:00 AM, and 3/19/2025 at 5:00 PM. The reasons noted by nursing staff were that the medication was unavailable and they were awaiting delivery from the pharmacy. Resident #64's Minimum Data Set (MDS) dated 3/05/25 documented she was cognitively intact, had impaired vision, and was diagnosed with glaucoma. In an interview on 3/31/25 at 12:29 PM, Resident #64 said the nurses did not give her the eyedrops for her glaucoma. She said the nurses told her it was because it had to be reordered and the pharmacy had not delivered it. In an interview on 4/03/25 at 9:48 AM, Nurse #9 said she was one of the nurses who administered medications during that time. She said if the medication was not available on the cart, a nurse could easily reorder the medication from the MAR computer program. She said she did not	F 760	all residents□ medications to validate availability and nurses□ knowledge of location of medication. Systemic changes made to ensure that the deficient practice will not recur. On 4/25/25 the Director of Health Services and/or Nurse managers began education to Nurses regarding knowing the location of medications and notification to pharmacy, the physician, resident and family when a medication is not available for prescribed administration, the six rights of medication administration and medication administration guidelines. Any nurse scheduled to work in a medication cart will be educated by 4/30/25 or be educated prior to their next scheduled medication pass time. This education has been added to the general orientation for all newly hired Nurses. On 4/25/25 the Director of Health Services and Nurse Management began the review of Nurses knowing the location of medications and appropriate administration of medications, reviews to validate the availability and the administration of the medications to the resident per physician orders will be completed weekly for four weeks then monthly until three months of sustained compliance is maintained quarterly thereafter. How will the facility plan to monitor its performance to make sure the solutions	

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F 760	Continued From page 15 remember the specific days she documented she was unable to give the medication or if she reordered the medication on that day. In an interview on 4/03/25 at 2:12 PM, Nurse #7 said she administered medications to Resident #64 on several of the days in February and March 2025 which noted the medication was not available. She said the medication was not on the medication cart and she was told by other nurses (names not recalled) that the medication had been reordered from the pharmacy. She said on one shift she worked (date not recalled), she was about to call the pharmacy to order the medication again, but then remembered that timolol maleate eyedrops were stored in the refrigerator when they were delivered from the pharmacy. She said she went and looked in the medication refrigerator and the medication was there. She said she put the medication on the cart and had not had a problem since. In an interview on 4/03/25 at 2:05 PM, the Pharmacy Consultant said the timolol maleate was sent as an automatic refill and was delivered to facility on 1/24/25, 2/11/25, 3/1/25, and 3/19/25. He said he checked the notes in pharmacy system and there were no notes regarding any insurance or delivery issues of the medication with no gap in delivery from the pharmacy records. He said the timolol maleate eyedrops were used to regulate the pressure in the resident's eye to treat glaucoma. In an interview on 4/03/25 at 3:27 PM, the Assistant Director of Health Services said she was the Director of Health Services at the time of the missed doses. She said she received complaints from Resident #64 and her family	F 760	are sustained: The Director of Health Services provided the synopsis of the medication review to the quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. The Clinical Competency Coordinator and/or Assistant Director of Health Services will present the percentage of newly hired nurses that have completed the 6 rights of medication administration, and medication administration guidelines protocol to the quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained quarterly thereafter. When will corrective action will be completed 5/1/2025	

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F 760	Continued From page 16 member (dates not recalled) that Resident #64 had missed several doses of the timolol maleate eyedrops because staff reported the medication was not available. She said she went to the medication refrigerator, where the eyedrops were stored when delivered from the pharmacy, and found the medication. She said she in-serviced the nurses on where to look for the medication and to look for them before ordering from the pharmacy. She said if there was a problem obtaining medications from the pharmacy, the facility had a back-up pharmacy that should have been called so the resident did not miss a dose of the medication.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/1/25

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F 761	Continued From page 17 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to date opened multi-dose pen injectors of insulin medication in 2 of 5 medication administration carts (100 hall and 200 hall), failed to remove expired multi-dose pen injectors of insulin from the medication cart drawer for 1 of 5 medication administration carts (200 hall). Findings included: 1.a. On 3/31/25 at 9:55 AM, an observation of the medication administration 100 hall cart with Nurse #1 revealed one opened and undated multi-dose vial of Lantus insulin pen fill. A review of the manufacturer's literature indicated to discard Lantus insulin multi-dose vial 28 days after opening. On 3/31/25 at 10:00 AM, during an interview, Nurse #1 indicated that the nurses who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse mentioned she had not administered expired medication this shift. 1.b. On 3/31/25 at 10:15 AM, an observation of the medication administration 200 hall cart with	F 761	Corrective action for the residents found to be affected by the deficient practice. On 3/31/25 the expired and/or undated medication was removed from the medication cart by the Director of Health Services and/or Nurses. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. The Director of Nursing and /or Nurse Managers verified that no other expired and/or undated medication were in the medication carts or medication rooms on 3/31/25. Systemic changes made to ensure that the deficient practice will not recur. On 4/25/25 the Director of Health Services and/or Nurse managers began education to all nurses regarding labeling and dating of medications when opened with emphasis on dating insulin pens when opened and placing their expiration date on the label also. Nurses not educated by 4/29/25 will be educated prior to their next scheduled shift and/or removed from the schedule. This education has been added to the general	

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F 761	Continued From page 18 Nurse #2 revealed one opened and undated multi-dose vial of Glargine Insulin pen fill, and one Admelog Solostar insulin pen fill, opened on 3/2/25, expired on 3/30/25. A review of the manufacturer's literature indicated to discard Lantus insulin multi-dose vial 28 days after opening. On 3/31/25 at 10:20 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated or expired multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. On 4/1/25 at 11:25 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible to check all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected that no expired items be left in the medication carts. On 4/1/25 at 12:30 PM, during an interview, the Administrator expected no expired items be left in the medication carts.	F 761	orientation of all newly hired nurses. The Director of Health Services and/or Nurse Managers review each medication cart and medication room weekly to ensure all medications have an open date and an expiration date if required. This review is completed weekly for eight weeks then monthly thereafter until three months of sustained compliance is maintained then quarterly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will present the analysis of the medication cart and medication room review to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: 5/1/2025	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/1/25

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F 812	Continued From page 19 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to cover facial hair during food service for 1 of 2 dietary staff (Cook #1) observed and clean the convection oven and the deep fryer. These practices had the potential to affect food served to residents. The findings included: 1. During a follow-up tour of the kitchen, an observation and interview with Cook #1 were conducted on 4/2/25 at 11:30 AM. Cook #1 had facial hair and was without facial hair covering while taking temperatures of the lunch meal items located in the steam table. Cook #1 stated he did not cover his facial hair because he was about to go on break. He stated he should have always covered his beard and mustache while in the kitchen. During a follow-up interview with the DM on	F 812	Corrective action for the residents found to be affected by the deficient practice. On 4/2/2025 the cook placed a beard guard on after identification notes. The convection oven and deep fryer were cleaned on 4/2/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Systemic changes made to ensure that the deficient practice will not recur. On 4/4/25 the Certified Dietary Manager began education with all the dietary staff on the cleaning scheduled for equipment	

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F 812	Continued From page 20 4/2/25 at 11:40 AM, she revealed that the dietary staff were trained most recently on facial hair coverings last Friday (3/28/25). All dietary staff should know how to always cover facial hair while in the kitchen and Cook #1 should have taken the food temperatures prior to going on break. The Administrator was interviewed on 4/3/25 at 11:03 AM. She revealed that Cook #1 should have covered his facial hair while in the kitchen. 2. An observation of the kitchen and interviews with the DM and Cook #1 were conducted on 3/31/25 at 10:31 AM. The convection oven doors were covered with a brown substance. Cook #1 stated the convection oven was last cleaned the weekend before last (3/22/25 or 3/23/25). The DM stated she was in the process of creating/posting a cleaning schedule. During a follow-up tour of the kitchen, an observation and interview with the DM were conducted on 4/02/25 at 11:39 AM. The convection oven doors had the same brown substance on both doors and the deep fryer was full of food particles in the oil and along the sides. The DM stated that the oven doors should have been cleaned after each use, and it looked like it had not been cleaned in a while. She further stated that the deep fryer should also be cleaned after each use, and it was last used yesterday (4/1/25). The last time the deep fryer was cleaned was on 3/28/25. There was an in-service provided on 3/28/25 about keeping kitchen equipment clean. The Administrator was interviewed on 4/03/25 at 11:06 AM. She revealed that a daily cleaning schedule should have been implemented for both	F 812	within the kitchen. Dietary staff who are not educated by 4/29/25 will be educated prior to their next scheduled shift and/or removed from the schedule. This education has been added to the general orientation of all newly hired dietary staff members. On 4/4/25 the Certified Dietary Manager began education with all dietary staff members related to the requirement of wearing hair nets and beard coverings. Dietary staff who are not educated by 4/29/25 will be educated prior to their next scheduled shift and/or removed from the schedule. This education has been added to the general orientation of all newly hired dietary staff members. The Administrator and/or Certified Dietary Manager will validate hair coverings and beard guards are worn appropriately by dietary staff members daily for seven days, weekly for four weeks then monthly thereafter until three months of sustained compliance is maintained, then quarterly thereafter. The Administrator and/or Certified Dietary Manager will review the kitchen equipment to validate cleanliness of the equipment weekly for four weeks, then monthly thereafter until three months of sustained compliance is maintained, then quarterly thereafter. Plans to monitor its performance to make sure that the solutions are sustained.	

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F 812	Continued From page 21 the convection oven and the fryer.	F 812	The Director of Certified dietary manager will present the analysis of the hair and beard covering compliance review to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. The Director of Certified dietary manager will present the analysis of the kitchen equipment cleanliness compliance review to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Date of compliance: 5/1/2025	