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	49E185	A. BUILDING ______ B. WING ______	03/19/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/16/21 through 03/19/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 27 resident reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare initial survey and Medicaid recertification survey was conducted 03/16/21 through 03/19/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 60 certified bed facility was 52 at the time of the survey. The survey sample consisted of 27 resident reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		4/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain resident dignity and privacy for 4 residents (Resident #18, Resident #250, Resident #23, Resident #24) in a sample of 27 residents. The findings included: 1. For Resident #18, the facility staff failed to get permission to enter his room on 03/16/2021	F 550	F550 S/S: E Resident Rights/ Exercise of Rights CFR(s): 483.10(a) (1) (2) 1. One to one education was provided to team members caring for residents #18, #250, #23, and #24 regarding permission to enter their room on April 9, 2021. 2. Administrator/designee will complete a 100% audit of staff entering resident rooms to observe and ensure staff obtain	

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F 550 Continued From page 2

resulting in a breach of Resident #18's privacy and devaluing his private space.

Resident #18, an 86-year old male, was admitted to the facility on 02/26/2020. Diagnoses included but were not limited to cerebral infarction, hypertension, and muscle weakness.

Resident #18's most recent Minimum Data Set with an Assessment Reference Date of 01/12/2021 was coded as an annual assessment. The brief interview for mental status was coded as 14 out of possible 15 indicative of intact cognition. Functional status for transfers was coded as requiring extensive assistance from staff with 2+ persons physical assistance for support. Balance during transitions and walking and moving from ceded to standing position was coded as not steady, only able to stabilize with human assistance. Functional limitation and range of motion was coded as upper and lower extremity impairment on one side. Urinary continence was coded as occasionally incontinent. Bowel continence was coded as frequently incontinent.

On 03/16/2021 at 1:38 P.M., this surveyor observed that Resident #18's call light was activated. Resident #18 gave this surveyor permission to enter the room and close the room door. Resident #18 was observed sitting up in his bed with the head of the bed elevated approximately 60 degrees. When asked about the call light, Resident #18 stated he had it on earlier to ask about his lunch. Resident #18 stated that staff brought his lunch but didn't turn off the call light. At 1:49 P.M., during the interview with Resident #18 and this surveyor, Certified Nurse Assistant A (CNA A) knocked on Resident

F 550

permission prior to entering the room by April 16, 2021.

3. DON/designee will educate team members on importance of maintaining resident dignity, privacy and permission prior to entering the resident room.

4. Administrator/designee will review 10% of resident rooms to ensure staff are obtaining permission prior to entering a resident room twice a week for 4 weeks and weekly for 8 weeks. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.

5. All corrective actions will be completed by April 23, 2021.

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F 550	Continued From page 3 #18's room door and immediately entered the room without Resident #18's permission. When asked about the process for entering rooms, CNA A stated she was entering the room to turn off the call light. CNA A then left the room, closed the door, knocked on the door, waited for a response, entered the room, turned off the call light, asked Resident #18 if he was done with lunch, then took his tray out of the room. When asked if staff entered the rooms without waiting for permission to enter, Resident #18 stated that staff, many times, enter the room without knocking. Resident #18 stated that one time he was using the urinal and "they just walk right in." On 03/19/2021 at approximately 1:30 P.M., the administrator and interim Director of Nursing were notified of findings. When asked about expectations for entering rooms, the interim DON stated staff should wait for a response before entering resident rooms. 2. For Resident #250, the facility staff failed to get permission to enter his room on 03/16/2021 resulting in a breach of Resident #250's privacy and devaluing his private space. Resident #250, Resident #250, a 69-year old male, was admitted to the facility on 12/22/2020. Diagnoses included but were not limited to coronary artery disease and hypertension. Resident #250's most recent Minimum Data Set with an Assessment Reference Date of 12/29/2020 was coded as an admission assessment. The brief interview for mental status was coded as 15 out of possible 15 indicative of intact cognition.	F 550		

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F 550	Continued From page 4	F 550		

On 03/16/2021 at 1:38 P.M., this surveyor observed Resident #250 sitting up in his bed with the head of the bed elevated approximately 60 degrees. Resident #250 and his roommate, Resident #18, were engaged in conversation. When Resident #250 and Resident #18 saw this surveyor in the hall, they waved and invited this surveyor into the room. During the interview with Resident #18 and this surveyor, Resident #18 would ask Resident #250 questions and include him in the conversation. At 1:49 P.M., Certified Nurse Assistant A (CNA A) knocked on the room door and immediately entered the room without asking permission to enter the room from Resident #250 or Resident #18. When asked about the process for entering rooms, CNA A stated she was entering the room to turn off the call light. CNA A then left the room, closed the door, knocked on the door, waited for a response, entered the room, turned off the call light. Resident #250 stated that their room door is usually open so staff just enter the room.

On 03/19/2021 at approximately 1:30 P.M., the administrator and interim Director of Nursing were notified of findings. When asked about expectations for entering rooms, the interim DON stated staff should wait for a response before entering resident rooms.

3. For Resident #23, the facility staff failed to get permission to enter his room on 03/16/2021 resulting in a breach of Resident #23's privacy and devaluing her private space.

Resident #23, Resident #23, a 72-year old female, was admitted to the facility on

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F 550	Continued From page 5	F 550		

09/30/2019. Diagnoses included but were not limited to heart failure and neurogenic bladder.

Resident #23's most recent minimum data set with an assessment reference state of 01/19/2021 was coded as an annual assessment. The brief interview for mental status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility, transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff.

On 03/16/2021 at 2:35 P.M., Resident #23 was observed in her bed lying supine and leaning on her left side. Resident #23 invited this surveyor into her room and gave permission to close the room door. At 2:44 P.M., during the interview with Resident #23 and this surveyor, Certified Nursing Assistant (CNA B) knocked on the room door and then immediately entered the room without waiting for a response. When asked about the process for entering rooms, CNA B apologized and stated she "came to check" on Resident #23. Resident #23 then stated that the nurse knows her door is usually open so she probably wanted to come in and check on me.

On 03/19/2021 at approximately 1:30 P.M., the administrator and interim Director of Nursing were notified of findings. When asked about expectations for entering rooms, the interim DON stated staff should wait for a response before entering resident rooms.

4. For Resident #24, the facility staff failed to get permission to enter his room on 03/16/2021 resulting in a breach of Resident #24's privacy

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F 550	Continued From page 6 and devaluing her private space. Resident #24, was admitted to the facility on 11/25/2019. Diagnoses included but were not limited to anxiety, depression, and bipolar disorder. Resident #24's most recent Minimum Data Set with an Assessment Reference Date of 01/19/2021 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "9" out of possible "15" indicative of moderate cognitive impairment. On 03/16/2021 at 2:35 P.M., Resident #24 was observed seated in her wheelchair beside her bed. Resident #24 smiled and nodded when this surveyor asked for permission to enter the room. At 2:44 P.M., during the interview with Resident #23 (Resident #24's roommate) and this surveyor, Certified Nursing Assistant B (CNA B) knocked on the room door and then immediately entered the room without waiting for a response from Resident #24 or Resident #23. When asked about the process for entering rooms, CNA B apologized and stated she "came to check" on Resident #23. On 03/19/2021 at approximately 1:30 P.M., the administrator and interim Director of Nursing were notified of findings. When asked about expectations for entering rooms, the interim DON stated staff should wait for a response before entering resident rooms.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/23/21

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F 641

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The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to accurately complete an assessment for 1 Resident (Resident # 1) in a survey sample of 27 residents.

Findings included:

For Resident # 1, the facility staff failed to accurately code Section L for Oral/Dental Status on the Minimum Data Set Assessments.

Resident #1 , a 58-year old male, was admitted to the facility on 01/27/2020. Diagnoses included but were not limited to chronic pain syndrome, cerebral infarction, dysphagia, anxiety disorder, hypokalemia, dysarthria, pain in left shoulder and vascular dementia.

Resident #1's most recent MDS (Minimum Data Set) with an Assessment Reference Date of 03/2/2021 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive to total assistance from one to two staff persons. For eating, Resident # 1 was coded as requiring supervision and set up only.

Review of the MDS (Minimum Data Set) with an Assessment Reference Date of 12/20/2020 was coded as an Annual assessment. The MDS Section L (Oral/Dental Status) coded Resident # 1 as having no dental problems.

F 641

F641-
S/S: D
Accuracy of Assessments CFR(s): 483.20 (g)
1. Resident #1 MDS was coded accurately for section L and submitted on April 9, 2021.
2. The Administrator/designee will complete a 100% audit of all residents MDS section L and review to ensure accuracy by April 16, 2021.
3. The Clinical Reimbursement Manager/designee will educate the MDS Coordinator on proper coding of section L on the MDS by April 8, 2021.
4. The Administrator/designee will audit 6 MDS weekly for 4 weeks and then 3 MDS weekly for 8 weeks to ensure proper coding of section L. The results of the audits will be reported to the QAPI committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis
5. All corrective actions will be completed by April 23, 2021.

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Review of the Admission Assessment dated 2/2/2020 revealed the MDS Section L (Oral/Dental Status) coded Resident # 1 as having no dental problems.

Section L - L 0200 Options to choose were:
A. Broken or loose fitting dentures,
B. No natural teeth or tooth fragments
C. Abnormal mouth tissue (ulcers, masses.....)
D. Obvious or likely cavity or broken natural teeth
E. Inflamed or bleeding gums or loose natural teeth
F. Mouth or facial pain
G. Unable to examine
H. None of the above were present

Further review of the clinical record revealed no documentation of Resident # 1 being admitted with poor dentition. The Admission MDS did not reflect a dental issue and the annual assessment did not either. The most recent MDS on 3/2/2021 was a quarterly assessment and did not address the oral/dental status.

However, on 3/19/2021 at 1:03 PM during an interview, the Medical Director stated he saw the Resident on 2/26/2021 and during that visit he "noted increasing dental pain and upper broken teeth." He stated Resident # 1 "had poor dentition every since coming to the facility. My exam noted the broken teeth but no evidence of infection...." (sic)

No other information was provided prior to exit.

F 656 SS=D — Develop/Implement Comprehensive Care Plan
CFR(s): 483.21(b)(1)

F 656 — Completion date: 4/23/21

§483.21(b) Comprehensive Care Plans

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F 656	Continued From page 9 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a comprehensive care plan for one resident (Resident # 1) in a survey sample of 27 residents.

The findings included:

For Resident # 1, the facility staff did not develop a comprehensive care plan to include plans for (A) limited range of motion and (B) did not develop measurable goals for the care area of dentition.

Resident #1, a 58-year old male, was admitted to the facility on 01/27/2020. Diagnoses included but were not limited to chronic pain syndrome, cerebral infarction, dysphagia, anxiety disorder, hypokalemia, dysarthria, pain in left shoulder and vascular dementia.

Resident #1's most recent Minimum Data Set with an Assessment Reference Date of 03/2/2021 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive to total assistance from one to two staff persons. For eating, Resident # 1 was coded as requiring supervision and set up only.

Review of the clinical record was conducted 3/17/2021 and 3/18/2021.

(A)

F 656

F656-
S/S: D
Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)
1. Resident #1 comprehensive care plan was updated to include his limited range of motion due to Hemiplegia and measurable goals for the care area of dentition by April 6, 2021.
2. The DON/designee will complete a 100% audit of all residents comprehensive care plan regarding those with limited range of motion and ensure measurable goals are completed for the care area of dentition by April 16, 2021.
3. The DON/designee will educate the nursing care plan team on updating and revising care plans as related to residents with limited range of motion and measurable goals for the care area of dentition.
4. DON/designee will perform audits on 6 resident care plans weekly for 4 weeks and 3 residents care plans weekly for 8 weeks to ensure a comprehensive care plan was developed for those residents with limited range of motion and measurable goals for the care area of dentition. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.
5. All corrective actions will be completed by April 23, 2021.

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The care plan listed the focus Problem areas to include areas
History of falls-
(Resident's name) has risk for falls and/or history of falls related to falls since admission, weakness, hemiplegia, pain, side effects of medications, poor safety awareness, behaviors (placing self on floor) impaired gait/balance, alteration in cardiac output, anticoagulant use, compromised quality of life and other problems.

(Resident's name) has potential for/ expressed/ demonstrated pain/discomfort related to: CVA (Cerebrovascular Accident), hemiplegia,

Review of the care plan revealed no care plan for the limited Range of Motion due to hemiplegia.

On 3/18/2021 at 12:02 PM, an interview was conducted with the Interim Director of Nursing who stated she would check to see if there was a care plan for Limited range of motion. The Director of Nursing looked at the care plan in the electronic medical record and stated the care plan talked about hemiplegia in the plans about falls and pain. The Administrator and Corporate Nurse were in the room with the Director of Nursing with the phone on speaker. The Corporate Nurse informed the surveyor of where to find specific requested notes in the electronic clinical record.

The Director of Nursing stated there was not a specific plan written for Limited Range of Motion. The Corporate Nurse, Administrator and Director of Nursing were informed that there was no care plan for Limited Range of Motion.

(B)

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F 656	Continued From page 12 On 3/19/2021 at 1:03 PM, the Administrator and administrative staff met with the surveyors. The Medical Director stated he wanted to discuss the dental issues of Resident # 1. The Medical Director stated Resident was seen on 2/26/2021 and during that visit he "noted increasing dental pain and upper broken teeth." He stated Resident # 1 "had poor dentition every since coming to the facility". A care plan was developed on 3/3/2021 to address the problem of dental problems and broken teeth. It was written as: Problem: ____ (Resident name) is at risk for dental problems r/t (related to) broken teeth effective 3/3/2021 Goals: Resident will not experience unavoidable decline/complications in oral hygiene through next review" However, the goal was unclear and not measurable. During the end of day debriefing, the facility Administrator, Director of Nursing, Corporate Nurse were informed of the findings. No further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/23/21

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F 657	Continued From page 13 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, the facility staff failed to review and revise the care plan for 1 resident (Resident # 1) in a survey sample of 27 residents. The findings included: For Resident # 1, the care plan was not reviewed and revised with the creation of a dental care plan until 3/3/2021 (9 days after the resident experienced the spontaneous loss of three teeth on 2/22/2021 and continued with sporadic pain.) The interdisciplinary care plan meeting was held on 3/11/2021.	F 657	F657 S/S: D Care Plan Timing and Revision CFR(s):483.21 (b)(2)(i)-(iii) 1. Resident # 1 comprehensive care plan has been reviewed and revised to include all of his dental care needs and related pain on April 9, 2021. Resident has an appointment with the dentist on April 22, 2021. 2. The DON/designee will complete a 100% audit of all resident□s dental care plans to ensure they are reviewed and revised for accuracy related to the resident□s oral/dental status and related pain.	

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F 657	Continued From page 14 Resident #1, a 58-year old male, was admitted to the facility on 01/27/2020. Diagnoses included but were not limited to chronic pain syndrome, cerebral infarction, dysphagia, anxiety disorder, hypokalemia, dysarthria, pain in left shoulder and vascular dementia. Resident #1's most recent Minimum Data Set with an Assessment Reference Date of 03/2/2021 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive to total assistance from one to two staff persons. For eating, Resident # 1 was coded as requiring supervision and set up only. Review of the clinical record was conducted on 3/17/2021 and 3/18/2021. Review of the Nurses Notes revealed documentation on 2/22/2021 at 15:47 (3:47 PM)-"Resident is requesting a dental appointment. I told him I would look into it. He reports 3 teeth have "exploded". No pain reported at this time. To follow up." The next Nurses Note about the dental issue was written on 2/26/2021 at 12:11 PM- Attempted to make resident an appointment at the (Name of Free Clinic) to see the dental department, this nurse was left on hold for 22 minutes. No answer at this time and no option for a voicemail; will call back at a later date .....MD notified."	F 657	3. The DON/designee will educate the nursing care plan team on timeliness of reviewing and revising care plans to meet resident care needs. 4. DON/Designee will perform audits on 6 care plans a week for 4 weeks and then 3 care plans a week for 8 weeks for timeliness and accuracy of resident□s oral/dental status and related pain. The results of the audits will be reported to the QAPI committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by April 23, 2021.	

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03/11/2021 13:13 (1:13 PM)
"Clinical Notes Care Plan Meeting held today with resident in his room. Present were: ___, RN (Registered Nurse),____ AD (Activities Director),___RD (Registered Dietitian), ___NP(Nurse Practitioner),____, Restorative CNA (Certified Nursing Assistant), ____ BSW(Social Worker). Discussed care, meals, medications, etc. Res requested info on dental care.
Explained that few dentists are accepting Medicaid as payer & staff have attempted to contact the local free clinic to inquire about their dental services with no answer. RD & NP discussed ways to limit further problems, ie (example) brush teeth, rinse mouth after eating or drinking soda & eliminating full sugar soda. Res cont'd (Continued) to complain that not enough was being done. Attempted to reassure him that staff will cont to look for dental care for him.

Review of the care plan revealed documentation of a dental care plan written on 3/3/2021. Then interdisciplinary care plan meeting was held and the care plan was reviewed on 3/11/2021.

Care plan
Problems:
____ (Resident name) is at risk for dental problems r/t (related to) broken teeth
effective 3/3/2021
Goals: Resident will not experience unavoidable decline/complications in oral hygiene through next review

Approaches:
Dental consults/cleanings as ordered
Staff to encourage/assist resident with dental hygiene as needed

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F 657	Continued From page 16 Praise positive efforts toward dental care/oral hygiene Medicated Mouth wash/oral rinse as ordered by MD: see MAT/TAR Notify MD of change in dental condition, gum irritation, etc On 3/18/2021 at 2:37 PM, an interview was conducted with the Social Worker who stated a care plan meeting was held in Resident # 1's room "last week." Review of the interdisciplinary notes revealed documentation of the interdisciplinary care plan meeting on 3/11/2021. During the care plan meeting, it was documented that Resident # 1 complained of dental pain and again requested a dental appointment. On 3/19/2021 at 10:02 AM, an interview was conducted with Resident # 1 who stated he did have a care plan meeting. Resident # 1 stated he asked to see a dentist when his teeth first exploded and had to keep asking. Resident # 1 stated his teeth do hurt but not all of the time. During the end of day debriefing on 3/19/2021, the Administrative staff was informed of the findings. No further information was provided.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		4/23/21

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F 686	Continued From page 17 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide necessary service associated with wound care for 1 resident (Resident #23) in a sample size of 27 residents. The findings included: For Resident #23, the facility staff failed to arrange for transportation to a wound clinic appointment on 03/16/2021. As a result, Resident #23's appointment for an evaluation by a wound physician was delayed by 13 days. Resident #23, Resident #23, a 72-year old female, was admitted to the facility on 09/30/2019. Diagnoses included but were not limited to heart failure and neurogenic bladder. Resident #23's most recent minimum data set with an assessment reference state of 01/19/2021 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for bed mobility, transfers, dressing, and personal hygiene were coded as requiring extensive assistance from staff.	F 686	F686 S/S: D Treatment/Services to Prevent/Heal Pressure Ulcer CFR(s): 483.25 (b)(1)(i)(ii) 1. Resident #23 appointment to the wound clinic was rescheduled and transportation was provided on March 29, 2021. 2. The DON/designee will audit 100% of residents who have appointments to ensure that transportation is arranged and confirmed by April 16, 2021. 3. DON/designee will educate clinical staff on arranging transportation for residents scheduled appointments. 4. DON/designee will review 3 resident appointments weekly for 8 weeks to ensure transportation is arranged and confirmed. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by April 23, 2021.	

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On 03/16/2021 at approximately 2:35 P.M., Resident #23 was observed in her bed lying supine and leaning on her left side. When asked if she had any concerns about the care she receives at the facility, Resident #23 stated that there were transportation issues today and as a result, she couldn't go to her wound clinic appointment. Resident #23 stated that she has a wound vac on a wound and wants "a second opinion."

On 03/17/2021, the clinical record was reviewed. A nurse's note dated 03/16/2021 at 12:13 P.M. documented, "Resident appointment for wound clinic at [name] rescheduled due to transportation issues. Appointment not [sic] set for March 29th at 10 am. All paperwork completed and sent to transportation center per facility protocol. MD [medical doctor] notified, RR [responsible representative] aware."

On 03/18/2021 at approximately 9:30 A.M., an interview with Licensed Practical Nurse A (LPN A) was conducted. When asked about the process for making transportation appointments, LPN A stated that the nursing supervisor usually does it. LPN A also stated that the transportation information is kept in a binder at the nurse's station. LPN A and this surveyor went to look in the transportation binder for Resident #23's appointment. LPN A located a document for Resident #23 dated 03/08/2021 entitled, "Transport Request." LPN A stated there should be a fax receipt to confirm the transport company was notified. LPN A then asked LPN B about it. LPN B looked through the documents in the binder and stated that the transport request "never got faxed." LPN A stated that she made an

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F 686	Continued From page 19 appointment today to reschedule the appointment for March 29th. This surveyor observed the transport request and the fax confirmation document for the rescheduled appointment on 03/29/2021 at 10:00 A.M. On 03/18/2021 at approximately 10:00 A.M., the administrator was notified of findings. A copy of their policy on providing transportation was requested. On 03/19/2021 at approximately 10:30 A.M., a copy of their policy last reviewed on 11/24/2020 entitled, "Business Continuity Plan." On page 25 of the policy under the header "Transportation Strategies", an excerpt documented, "[Facility] utilizes the system transfer center to coordinate transportation resources." "[Facility] also holds a contract with [company name] transportation for routine transportation needs."	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to mitigate accident hazards for 5 Residents (Resident #18, #23, #24, #27, #35) in a survey	F 689	F689 S/S: E Free of Accident Hazards/ Supervision/ Devices CFR(s): 483.25 (d)(1)(2) 1. Residents #18, #23, #24, #27 needs	4/23/21

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F 689	Continued From page 20 sample of 27 Residents. The facility staff failed to respond timely to Resident #18, #23, #24, #27, and #35's call for assistance, using the Resident call bell system. The findings included: On 3/16/21, during initial tour of the facility, multiple Residents (Resident #18, #23, #24, #27) expressed concerns of having to wait extended periods of time, (over an hour) for staff to respond to their calls for assistance. During the survey from 3/16/21 until 3/19/21, several occurrences of Resident's engaging their call bell were observed while Surveyor A was in the room with the Resident. Surveyor A observed the call bells to go off in excess of 15 minutes on each occurrence before the facility staff responded. On 03/17/21 02:30 PM, during a Resident Council group interview, multiple Residents verbalized concerns over the lack of staff's timely response to call bells and stated, "one will come in ask what you want, turn your bell off and then they don't come back. they will say I'm not your aide, ill go get her but then no one shows up". Review of the Resident Council minutes from December, January, and February revealed call bell response time as a topic of ongoing concern. On 03/18/21 at 9:28 AM, while Surveyor B was in the front office, Surveyor B kept hearing a beeping noise. Surveyor B looked to see where it was coming from and saw on the computer screen several call bells were listed, one read, "Room 35 B PRS ATT (personal attention) 26	F 689	were met on March 16, 2021. Resident #35 needs were met on March 18, 2021. 2. The Administrator/designee will print and review 100% of resident call bell reports and follow-up with the staff regarding results by April 9, 2021. 3. DON/designee will educate all departments on the No Pass Zone regarding the expectation of everyone responding timely to call bells to meet resident needs. 4. The Administrator/designee will print and review call bell reports daily for measuring timely responses. Administrator/designee will follow up with team members and review results as appropriate. The results of the audits will be reported to the QAPI committee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by April 23, 2021.	

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F 689	Continued From page 21	F 689		

min" and was actively counting time.

On 03/18/21 at 10:48 AM, an interview was held with Resident #35, who resided in room 35 B. The Resident acknowledged he initiated his call bell this morning, "I needed staff to open my butter packet for my breakfast". When asked about call bell response, Resident #35 said sometimes he has to wait a little while for assistance, but this morning was not unusually long. When asked if he ever has to wait over an hour he stated "yes, but on average is isn't quite that long. The problem is how they do things and the lack of personnel".

On 3/18/21, the facility Administrator was asked to provide call bell logs for the past 2 weeks for Residents #18, #23, #24, #27, and #35. Review of these logs revealed that Resident's requests for assistance went as long as, 1 hour and 45 minutes before staff responded and disengaged the call light. Additionally, the following was noted on the call bell logs:
* Resident #18's request for assistance on 3/14/21 went 1 hour and 45 minutes, before it was responded to.
* Resident #23's request for assistance on 3/8/21 went 41 minutes before it was responded to.
* Resident #24's request for assistance on 3/11/21 went 1 hour and 4 minutes before it was responded to.
* Resident #27's request for assistance on 3/11/21 went 57 minutes before it was responded to.
* Resident #35's request for assistance on 3/18/21 went 45 minutes before it was responded to.

On 3/18/21 at 11:41 AM, an interview was held

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F 689	Continued From page 22 with the facility Administrator. The Administrator was made aware of the concern of Resident's expressing concerns and the call logs showing delayed response to call bells. The Administrator stated, "that's actually a QA (Quality Assurance) item, everyone is to respond to call bells, we go in, see what they need, cut the call light off and if we were not able to meet their need we will engage it (the call bell) again. Some people don't agree with this process". When shown the call bell logs she provided and some of the response times were pointed out, the Administrator stated, "I think it has improved slightly, we still have opportunity". On 3/18/21 at 12:15 PM, the facility Administrator provided the survey team with some documents in an effort to allege past non-compliance. The provided documents included a QA meeting agenda dated 9/9/20, which noted "call bells" as a topic of discussion and a document titled "Clinical Operations Report Healthcare 2021" which indicated the "average monthly call bell response time" was being monitored for the months of January and February. The Administrator stated, "that the expectation is that call bells be answered in less than 5 minutes". The monitoring for January and February indicated the average call bell time exceeded their expectation of 5 minutes. On 3/18/21, review of the facility policy titled "Call Systems- Call Bell/Signal Light" was reviewed. This policy stated, "Answer the call bell promptly". On 3/19/21 during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the extended call-bell wait times and Resident's lack of accommodation of needs.	F 689		

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F 689	Continued From page 23 They were also notified that since it is an ongoing issue at the time of survey, past-noncompliance would not be accepted. No further information was provided.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the medication pour and pass observation error rate was less than 5% for 1 Resident (Residents #29) in a sample size of 27 residents. There were 2 medication errors (wrong dose and expired medication administered) in 34 opportunities resulting in an 5.88% error rate. The findings included: Resident #29 was admitted to the facility on 10/15/19. Diagnoses for Resident #29 included but were not limited to: atrial fibrillation, congestive heart failure, glaucoma, and late onset Alzheimer's. On 3/17/21 at 9:59 AM, LPN B was observed to prepare and administer medications to Resident #29. Medications administered included: Cartia, Forosemide, metoprolol, potassium chloride, Cosopt eye drops, acetaminophen, UTI stat, and	F 759	F759 S/S: D Free of Medication Error Rate 5% or More CFR (s): 483.45 (f)(1) 1. The DON educated licensed nurse LPN B responsible for the medication errors for resident #29 on March 19, 2021. The DON reviewed the medication administration policy and procedure with focus on triple check of medications prior to administration, expiration dates, and the importance of following provider orders. The provider and responsible representative were notified of the medication errors for resident # 29 on March 17, 2021. Resident #29 had no adverse outcomes as a result of the medication errors. The resident□s medications were audited and all were corrected as of March 17, 2021. 2. The DON/designee will complete a 100% audit of the medication carts for expired medications and review of	4/23/21

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F 759	Continued From page 24 Vitamin D3. During the medication administration observation, LPN B prepared the medications and provided Resident #29 with one Vitamin D3 tablet from the bottle. Surveyor B read the pharmacy label on the bottle which indicated "Vitamin D3, 25mcg, chewable give 2 tablets". LPN B during medication preparation was asked "how long are these drops good for" when LPN B pulled out the Cosopt eye drops. LPN B stated, "I am not sure I will have to look". Surveyor B observed the brown zip lock pouch the eye drops were in to have "date opened 2/15/21" hand written. Prior to administration of medication, LPN B referenced a document titled "medications with shortened expiration dates" which stated, "Cosopt: unused individual use containers can be stored in open foil pouch up to 15 days". LPN B then proceeded to administer one drop into Resident #29's left eye. At the conclusion of the administration of Resident #29's medication administration, Surveyor B asked LPN B to read the orders for the Vitamin D3 again". LPN B stated, "I was supposed to give her two". Surveyor B then asked LPN B to read the "medications with shortened expiration dates" again for the Cosopt and reference the date they were opened. LPN B stated, "I shouldn't have given them, they were out of date". LPN B stated she had "misread" the document. On 3/17/21, a review of Resident #29's electronic health record (EHR) was conducted which included the physician orders. An order dated 11/27/2019, read: "cholecalciferol (vitamin D3) 1,000 unit chewable tablet (2,000 units) one time	F 759	medication orders to the current EMR by April 16, 2021. 3. DON/Designee will in-service the licensed nurses on the facility policy of medication administration, the 8 rights of medication administration, and checking medication expiration dates by April 16, 2021. 4. DON/designee will complete a med pass audit to include the 8 rights of medication administration and expiration dates are checked prior to administration for 4 residents weekly for 1 month and 4 residents monthly for 3 months and then 1 resident per month. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by April 23, 2021.	

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F 759	Continued From page 25	F 759		

daily for Vitamin D deficiency". An additional order read, ""Cosopt 22.3 mg-6.8 mg/mL eye drops (1 gtt) drops left eye two times daily" which had a start date of 9/19/20.

On 03/17/21 at 02:32 PM, LPN C was asked how long are eye drops good for, LPN C stated, "eye drops are good for 14 days after opening". When asked what is the importance of knowing when they are opened, LPN C stated, "for us to know when they expire and so they don't run out". LPN C was asked what is the risk of giving eye drops beyond 14 days after opening, she stated, ""we could give them an infection." She was asked what to do if they are not dated? She said, "if they don't have an open date and are beyond 14 days of receipt, I wouldn't give it, I would call pharmacy for STAT (immediate/urgent) reorder, we don't want them to go without."

On 3/17/21 at 5:03 PM, Surveyor B interviewed the Director of Nursing (DON) and asked what her expectations are for medication administration. She stated, "I would expect them (Residents) to receive them within the scheduled time frame, them to be in the correct position, in a private place, the correct dosage, route, the 5 rights of medication administration". When asked what her expectation is regarding the use multi-use items such as eye drops, insulin vials, etc., the DON stated, "when they open it they should be labeled with the date opened". When asked how long those items are good for, the DON stated, "it varies for each medication, we can reach out to the pharmacy and our rep (representative) helps us with meds that have shortened expiration dates".

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F 759	Continued From page 26 On 3/18/21, the facility policy titled "Medication Administration" was reviewed. This policy stated: "preparing medications: refer to medication administration record (MAR) to review medication; verify medication strength, dose and labeled directions. Date all open medications". On 03/17/2021 and again on 3/19/21, during the end of day meetings, the Administrator and DON were notified of findings and offered no further documentation or information throughout the survey.	F 759		
F 760 SS=D	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 observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure Residents are free to significant medication errors for 3 Residents, (Resident #38, #16, and #13) in a survey sample of 27 Residents. 1. For Resident #38, the facility staff administered expired insulin 3/11/21-3/17/21. 2. Resident #16 received expired insulin three times daily from 3/9/21-3/17/21, and once on 3/18/21. 3. The facility staff failed to ensure Resident #13 did not receive expired insulin. The findings included:	F 760	F760 S/S: D Residents are Free of Significant Med Errors CFR (s): 483.45 (f)(2) 1. Expired insulins for residents #38, #16, #13 were removed from the medication storage, destroyed, and re-ordered from the pharmacy on March 17, 2021. The provider and responsible representative were notified of the medication error on March 17, 2021. Residents #38, #16, #13 experienced no adverse outcomes from the expired insulin. The resident□s medications were audited and all were corrected on March 17, 2021. 2. The DON/designee will complete a 100% audit of all medication carts to	4/23/21

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F 760	Continued From page 27 1. Resident #38 was administered expired insulin from 3/11/21-3/17/21. Resident #38 was admitted to the facility on 08/05/2020. Diagnoses for Resident #38 included but were not limited to: cerebral infarction, encephalopathy, aphasia, type 2 diabetes, and atrial fibrillation. On 3/17/21 at 2:15 PM, during medication storage review the following were identified: * A multi-dose vial of LISPRO, which was labeled as Resident #38's had an open date of 2/10/21. This medication had a label from the pharmacy that read, "store using directions provided throw away any medication that remains 28 days after first use". LPN A was asked how long insulin is good for and she stated, "insulin is good for 45 days from opening date". * A multi-dose vial of Lantus was noted which had an open date of 2/20/21. The label read, " "store using directions provided throw away any medication that remains 28 days after first use". Surveyor B pointed the label out to LPN A and said read it and said, "oh 28 days, I was wrong, we are going to have to get rid of both of these, thank you for showing me that". LPN A confirmed Resident #38 had been administered both of these insulin's. On 03/17/21 at 02:21 PM, LPN A called the pharmacy to re-order Resident #38's insulin. Review of the medication administration record (MAR) for Resident #38 revealed the Lispro was last administered 3/17/21. Review of the physician orders revealed that Resident #38 receives this insulin three times daily. Resident #38's orders revealed he receives 13 units every	F 760	ensure there are no outdated medications by April 9, 2021. 3. The DON/designee will provide education to licensed staff on the 8 rights of medication administration and to check expiration dates prior to administration by April 16, 2021. 4. DON/designee will audit all medication carts weekly for expired medication. DON/designee will complete a med pass audit to include the 8 rights of medication administration and check for expiration dates weekly for 8 weeks. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by April 23, 2021.	

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F 760	Continued From page 28 morning and 23 units at bed time daily. The MAR was signed off on administration twice daily as ordered. Review of the Lantus manufacturer "prescribing information", package insert provided by the facility indicated on page 22 stated, in-use (opened) Lantus insulin is to be stored for 28 days. Page 4 of the manufacturer "Instructions for Use" stated, "The Lantus vials you are using should be thrown away after 28 days, even if it still has insulin left in it". 2. Resident #16 received expired insulin three times daily from 3/9/21-3/17/21, and once on 3/18/21. Resident #16 was admitted to the facility on 7/29/19. Diagnoses for Resident #16 included but were not limited to: dementia, peripheral neuropathy, type 2 diabetes mellitus, hypertension and coronary artery disease. On 03/17/21 at 02:32 PM, LPN C assisted Surveyor B with observation of insulin on the medication cart 1. This observation revealed: * Resident #16's Lispro kwik 100U/ML pen, had an opened date of 2/27/21. LPN C stated, "I think that is a 14 day one, but most insulin is good for 28 days after opening". LPN C was asked if Resident #16 had been receiving the expired insulin and LPN C confirmed "yes they have been receiving it daily". When asked what the risk associated with expired insulin is, LPN C stated, "it wouldn't be effective and could cause them to go too high (referring to their blood sugar)".	F 760		

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F 760	Continued From page 29	F 760		

Review of the facility's document titled "Mediations with shortened expiration dates" noted that Lispro kwik pen is only good for 10 days after being opened. Therefore, the Lispro kwik pen should have been discarded on 3/8/21.

On 3/18/21 a review of the clinical chart for Resident #16 was conducted. Review of the physician orders indicated on 2/24/21 the physician ordered Resident #16 to receive Lispro Kwik pen 4 units three times daily. The MAR revealed Resident #16 had continued to receive the expired insulin three times daily on 3/9-3/17, and one dose on 3/18/21.

3. The facility staff failed to ensure Resident #13 did not receive expired insulin.

Resident #13 was admitted to the facility on 2/6/18. Diagnoses for Resident #13 included but were not limited to: cerebrovascular disease, ataxia, chronic obstructive pulmonary disease and type 2 diabetes mellitus with diabetic neuropathic arthropathy.

On 03/17/21 at 02:32 PM, LPN C assisted Surveyor B with observation of insulin on the medication cart 1. This observation revealed:

* Resident #13's Aspart Flex Pen 100U/ML (Novolog) had no opened date. The date it was filled was 1/30/21. LPN C confirmed it has been opened and used but she doesn't know the date it was opened so she could only go by the date filled.

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F 760	Continued From page 30 * Resident #13's Basaglar Kwikpen 100U/ML had no open date, LPN C stated, "it was filled 1/6". LPN C confirmed "yes it has been opened and given. I don't see an open date either". LPN C was asked if Resident #13 had been receiving these expired insulin and LPN C confirmed "yes they have been receiving it daily". When asked what the risk associated with expired insulin is, LPN C stated, "it wouldn't be effective and could cause them to go too high (referring to their blood sugar)". Review of the facility's document titled "Mediations with shortened expiration dates" noted that Aspart Flex Pen is only good for 14 days after being opened. The Basaglar Kwikpen is good for 28 days. On 3/18/21 a review of the clinical chart for Resident #13 was conducted. Review of the physician orders indicated the physician ordered Resident #13 to receive Aspart Flex pen by sliding scale four times daily. The Basaglar Kwik pen was ordered for 30 units to be administered twice daily. Resident #13 was noted on the MAR to receive both of these insulin's daily for the month of March as ordered. Review of the manufacturer "Instructions for Use" information provided by the facility staff for the Aspart Flex Pen read on page 5, "The FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it". Review of the manufacturer "Instructions for Use" information provided by the facility staff for the Basaglar Kwik Pen read, "the Pen you are using should be thrown away after 28 days, even if it	F 760		

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F 760	Continued From page 31 still has insulin left in it". On 3/17/21 at 5:03 PM, Surveyor B interviewed the Director of Nursing (DON) and asked what her expectations are for medication administration. She stated, "I would expect them (Residents) to receive them within the scheduled time frame, them to be in the correct position, in a private place, the correct dosage, route, the 5 rights of medication administration". When asked what her expectation is regarding the use multi-use items such as eye drops, insulin vials, etc., the DON stated, "when they open it they should be labeled with the date opened". When asked how long those items are good for, the DON stated, "it varies for each medication, we can reach out to the pharmacy and our rep (representative) helps us with meds that have shortened expiration dates". When asked why this is important she stated, "so you know when to discard it". On 3/19/21 at 9:46 AM, an interview was held with LPN D. She said, "there are many types of insulin but on average it is good for 28 days from the time we open it usually, but it depends on each insulin". She showed an insulin which had an open date written on it. She was asked what she would do if it didn't have an open date, LPN D responded "I would throw it out". LPN D asked what the importance is of it having the date it was opened, she said "so we know when it expires, everything has an expiration date for a reason". Review of the facility policy titled, "Medication Storage" read, "10. expired and discontinued medications are returned/destroyed in a timely manner, in accordance with facility policies and timeframes.....19. All opened, multi-dose	F 760		

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F 760	Continued From page 32 containers must be dated on both the box and the vial/bottle or on the bottle/vial (if not in a box) and discarded according to the "Recommended Minimum Medication Storage Parameters. Insulin products (all vials) discard 28 days after opening (except Levemir (insulin detemir) which can be used up to 42 days after opening)". On 03/17/2021 and again on 3/19/21, during the end of day meetings, the Administrator and DON were notified of findings No further information was provided.	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 abuse, except when the facility uses single unit	F 761		4/23/21

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F 761

Continued From page 33

package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility documentation review, the facility staff failed to date medications after opening them.

Two medications were found to be opened, undated, and available for administration to Residents #38, and #13.

The Findings included:

On 3/17/21 at 1:57 P.M., a review was conducted of medication storage. Surveyor B was accompanied by LPN A.

A vial of Tuberculin Purified Protein Derivative was opened and undated. Licensed Piratical Nurse A (LPN A) was asked about the importance of knowing the date it was opened. She stated, "It's important to know when opened and if expired, we are supposed to date when we open it and initial it."

On 3/17/21 at approximately 2:15 P.M., an audit was conducted of Medication Cart B. Resident #38's LISPRO insulin was opened and undated. LPN A stated, "Insulin is good 45 days from opening date." The medication vial had a label on it that read, "store using directions provided throw away any medication that remains 28 days after first use." When asked if she could locate the date that it was opened, LPN A stated, "No ma'am I can not. I do not see an open date...."

The facility's Pharmacy Medication with

F 761

F761
S/S: D
Label/Store Drugs and Biologicals
CFR(s): 483.45 (g)(h)(1)(2)
1. Resident #38 and #13 opened and undated medications were disposed of and re-ordered from the pharmacy on March 17, 2021.
2. The DON/designee will complete a 100% audit of the medication carts and medication refrigerator to ensure there are no open and un-dated medications by April 9, 2021.
3. DON/designee will provide education to licensed staff on importance that all opened medications must be dated.
4. DON/designee will audit all medication carts and refrigerator weekly for 8 weeks to ensure all opened medications are dated. The results of the audits will be reported to the QAPI committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.
5. All corrective actions will be completed by April 23, 2021.

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Shortened Expiration Dates document was on each medication cart, and accessible to all nurses.

On 3/17/21 at 2:21 P.M., an audit was conducted of Medication Cart A. Resident #13's Novolog was opened and undated. LPN C confirmed that the Novolog had been opened. When asked about the possible risk of being undated, she stated, "It wouldn't be effective and could cause them to go too high."

On 1/19/21 at 9:46 A.M., an interview was conducted with LPN D. She stated, "There are many types of insulin but on average it is good for 28 days from the time we open it usually, but it depends on each insulin. " She then showed the surveyor a vial of insulin that had an open date written on it. When asked what she would do if it did not have an open date, she stated that she would throw it out. When asked about the importance of doing so, she stated, "So we know when it expires, everything has an expiration date for a reason."

On 3/17/21 in the afternoon an interview was conducted with the Director of Nursing (Employee B). When asked about her expectation regarding open dates, she stated, "So you know when to discard it."

ON 3/17/21 a review was conducted of facility documentation. An excerpt from the Medication Storage policy dated 2/28/21 read, "Expired and discontinued medications are returned/destroyed in a timely manner...medication and treatment carts are free of expired medications and biologicals."