STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	R-C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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	{E 000}	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged Compliance is May 24, 2022.	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit survey to the standard survey conducted on 03/22/2022 through 03/24/2022 was conducted 05/10/2022 through 05/12/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 10 current resident reviews, Residents #101 through #110.	{F 000}	Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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).	{F 656}	1. Resident #102 now has documentation that Levothyroxine is available and being administered per MD orders. Resident #105 now has documentation that Fluoxetine is available and being administered per MD orders. 2. An audit will be conduct by May 23, 2022 of residents with orders for thyroid replacement medication and medication to treat depression since May 1, 2022 to ensure medications are available and given per MD orders. 3. Licensed Nurses will be re-educated by May 23, 2022 regarding procedures when medications are not available. Re-education will also include review of the pharmacy ordering process with cut off times as well as utilization of the Omnicel.	5/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Shuma LNHA — TITLE: Administrator — (X6) DATE: 5/24/22

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 656}	Continued From page 1 (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 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for two of ten residents in the survey sample, Resident #102 (R102) and #105 (R105). The findings include: 1. The facility staff failed to implement the care plan for the administration of thyroid replacement medication for R102. On the most recent MDS (minimum data set) assessment, a Medicare admission/five day assessment, with an assessment reference date of 5/4/2022, the resident scored a 7 out of 15 on	{F 656}	4. DON/designee will conduct audits of residents' MARs to include thyroid medication and medication to treat depression 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure medications are available. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee's recommendations.	

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{F 656}	Continued From page 2 the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. The comprehensive care plan dated 4/29/2022, documented in part, "(R102) is at risk for complications of hypothyroidism such as: intolerance to cold, decreased appetite, weight gain, dry skin, mood changes, constipation, fatigue & bradycardia R/T (related to): Dx (diagnosis) Hypothyroidism." The "Interventions" documented in part, "Administer thyroid replacement therapy as ordered." A physician order dated, 4/28/2022, documented Levothyroxine Sodium Tablet (Used to treat hypothyroidism [condition where the thyroid gland does not produce enough thyroid hormone]) (1) 75 MCG (micrograms); Give 1 tablet by mouth in the morning for Thyroid." The April 2022 MAR (medication administration record) documented the above order. On 4/29/2022, a "5" was documented in the box for the nurse to sign off the medication as given. The code at the bottom of the MAR documented a "5 = Hold/See Nurse Note." The nurse's note dated 4/29/2022 at 6:23 a.m. documented, "Waiting on medication from pharmacy." The pharmacy manifest, the delivery of the medications to the facility document, was dated 4/29/2022. The medications were delivered to the facility at 4:06 a.m. on 4/29/2022. The [Name of Automated Medication Dispensing System] documented the machine had	{F 656}		

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{F 656}	Continued From page 3 Levothyroxine 75 MCG, quantity on hand, was documented as "9." The [Name of Automated Medication Dispensing System] documentation of all medications removed from the system between 4/21/2022 and 4/29/2022 failed to evidence documentation of Levothyroxine having been removed from the system. An interview was conducted with RN (registered nurse) #1 on 5/11/2022 at 2:27 p.m. When asked the purpose of the care plan, RN #1 stated it's the goals of care for that resident. It's a guide of the care the resident is to receive. When asked, if the care plan documented to give medications as ordered and the medication is not given as ordered, is that following the care plan, RN #1 stated, no. The facility policy, "Care Planning" documented in part, "Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes a measurable objectives and time frames to meet a residents medical, nursing and mental and psychosocial needs." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were made aware of the above concern on 5/11/2022 at 12:19 p.m. No further information was provided prior to exit. (1) This information was obtained from the	{F 656}		

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{F 656}	Continued From page 4 following website: https://medlineplus.gov/druginfo/meds/a682461.html. 2. The facility staff failed to implement the care plan for the administration of medication to treat depression for R105. On the most recent MDS (minimum data set) assessment, an Admission/Medicare 5 day assessment, with an assessment reference date of 4/27/2022, the resident scored a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired for making daily decisions. The comprehensive care plan dated, 4/21/2022, documented in part, "Focus: (R105) is at risk for adverse reactions and side effects r/t (related to) psychotropic medication. Resident takes: Antidepressant." The "Interventions" documented in part, "Administer antidepressant medications per orders." The physician order dated 4/20/2022, documented, "Fluoxetine HCL (hydrochloride) (used to treat depression) (1) HCL (hydrochloride) Capsule 10 MG (milligrams); Give 1 capsule via PEG - Tube (gastrointestinal tube used for feeding and medications) one time a day for depression." The MAR (medication administration record) documented the above order for Fluoxetine. On 4/21/2022, the box for the scheduled dose documented a "5." The code at the bottom of the MAR documented a "5 = Hold/See Nurse Note."	{F 656}		

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{F 656}	Continued From page 5 The nurse's note dated, 4/21/2022 at 11:46 a.m. failed to evidence documentation as to why the medication was not administered. The pharmacy manifest, the delivery of the medications to the facility document, was dated 4/21/2022. The manifest documented the medications were received at the facility on 4/21/2022 at 1:56 p.m. The [Name of Automated Medication Dispensing System] documented the machine had Fluoxetine HCL 10 MG, quantity on hand documented, "10." The [Name of Automated Medication Dispensing System] documentation of all medications removed from the system between 4/21/2022 and 4/29/2022 failed to evidence documentation of Fluoxetine having been removed from the system. An interview was conducted with RN (registered nurse) #1 on 5/11/2022 at 2:27 p.m. When asked the purpose of the care plan, RN #1 stated it's the goals of care for that resident. It's a guide of the care the resident is to receive. When asked, if the care plan documented to give medications as ordered and the medication is not given as ordered, is that following the care plan, RN #1 stated, no. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were made aware of the above concern on 5/11/2022 at 12:19 p.m.	{F 656}		

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{F 656}	Continued From page 6 No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a689006.html	{F 656}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review, the facility staff failed to administer eye drops according to professional standards for two of 10 residents in the survey sample, Residents # 109 (R109) and Resident # 110 (R110). The findings include: 1. The facility staff failed to wear gloves when administering eye drops to (R109). (R109) was admitted with diagnoses that included but were not limited to: macular degeneration. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/11/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section "B1000. Vision" coded (R109) as	{F 658}	1. Licensed Nurse #1 was re-educated on proper procedures when administering eye drops. No ill effects noted to Residents #109 and #110. 2. All residents with orders for eye drops have the potential to be affected by the alleged deficient practice. 3. Licensed Nurses will be re-educated by May 23, 2022 regarding the correct procedure on administering eye drops by the DON/ Designee. 4. DON/designee will conduct random medication administration observations of residents with eye drops 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee's recommendations.	5/24/22

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{F 658}	Continued From page 7 moderately impaired. On 05/11/2022 at approximately 8:55 a.m., an observation of LPN (licensed practical nurse) # 1 administering eye drops (Systane (1) Solution) to (R109) revealed that they were not wearing gloves when they administered the eye drops. The physician's order for (R109) documented in part, "Systane Solution 0.4-0.3 % (percent) (Polyethyl Glycol-Propyl Glycol) Instill 1 drop in both eyes three times a day for dry eyes. Order Date: 03/01/2020. Start Date: 03/02/2020." On 05/11/2022 at approximately 11:21 a.m., n interview was conducted with LPN # 1 regarding their administration of (R109's) eye drops. LPN # 1 stated that they were not wearing gloves when they administered (R109's) eye drops. When asked to describe the correct procedure when administering eye drops LPN # 1 stated that gloves should be worn when administering eye drops to prevent the spread of infection. On 05/11/2022 at approximately 12:39 p.m., ASM (administrative staff member) # 2, director of nursing, was asked what standard of practice the nursing staff follow. ASM # 2 stated that they follow the facility's policies, procedures and Lippincott. On 05/11/2022 at approximately 1:45 p.m., ASM # 2 provided a standard from the Lippincott website: https://procedures.lww.com/lnp/search.do. The document "Eyedrop [sic] administration" documented in part, "Implementation. Put on gloves to comply with standard precautions."	{F 658}		

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{F 658}	Continued From page 8 On 05/11/2022 at 12:19 p.m., ASM # 1, administrator, ASM # 2, ASM # 3, regional director of operations and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) Lubricating eye drops for the temporary relief of burning and irritation due to dryness of the eye. This information was obtained from the website: https://www.medline.com/product/Systane-Ultra-Lubricant-Eye-Drops/Z05-PF81063. 2. The facility staff failed to wear and change gloves when administering eye drops to (R110). (R110) was admitted with diagnoses that included but were not limited to: glaucoma. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/11/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition for making daily decisions. Section "B1000. Vision" coded (R110) as moderately impaired. On 05/11/2022 at approximately 8:26 a.m., an observation of LPN (licensed practical nurse) # 1 administering eye drops (Brimonidine (1) and Dorzolamide (2)) to (R110) revealed that they were not wearing gloves when they administered the eye drops.	{F 658}		

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{F 658}	Continued From page 9 The physician's order for (R110) documented in part, "Brimonidine Tartrate Solution 0.1 %. Instill 1 drop in left eye one time a day for glaucoma. Order Date: 05/02/2022. Start Date: 05/03/2022." and "Dorzolamide HCl (hydrochloride) Solution 2 % Instill 1 drop in left eye one time a day for glaucoma. Date: 05/02/2022. Start Date: 05/03/2022." On 05/11/2022 at approximately 11:21 a.m., n interview was conducted with LPN # 1 regarding their administration of (R110's) eye drops. LPN # 1 stated that they were not wearing gloves when they administered (R110's) eye drops. When asked to describe the correct procedure when administering eye drops in both eyes LPN # 1 stated that gloves should be worn when administering eye drops and that their gloves should be changed and their hands should be washed between administering the medication form one eye to the other eyes to prevent the spread of infection. On 05/11/2022 at approximately 12:39 p.m., ASM (administrative staff member) # 2, director of nursing, was asked what standard of practice the nursing staff follow. ASM # 2 stated that they follow the facility's policies, procedures and Lippincott. The "Eyedrop [sic] administration" documented in part, "Critical Notes. 5. If instilling drops into both eyes, remove gloves between eyes, perform hand hygiene and apply new gloves." On 05/11/2022 at 12:19 p.m., ASM # 1, administrator, ASM # 2, ASM # 3, regional director of operations and ASM # 4, regional nurse consultant, were made aware of the above	{F 658}		

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{F 658}	Continued From page 10 findings. No further information was provided prior to exit. References: (1) Used to lower pressure in the eyes in patients who have glaucoma (high pressure in the eyes that may damage nerves and cause vision loss) and ocular hypertension. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601232.html. (2) Is used to treat glaucoma, a condition in which increased pressure in the eye can lead to gradual loss of vision. Dorzolamide is in a class of medications called carbonic anhydrase inhibitors. It works by decreasing the pressure in the eye. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html.	{F 658}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the	{F 684}	1. Resident #102 now has documentation that Levothyroxine is available and being administered per MD orders. Resident #105 now has documentation that Fluoxetine is available and being administered per MD orders. 2. An audit will be conduct by May 23, 2022 of residents with orders for thyroid replacement medication and medication to treat depression since May 1, 2022 to ensure medications are available and given per MD orders. 3. Licensed Nurses will be re-educated by May 23, 2022 regarding procedures when medications are not available. Re-education will also include review of the pharmacy ordering process with cut off times as well as utilization of the Omnicel.	5/24/22

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{F 684}	Continued From page 11 facility staff failed to ensure two of ten residents in the survey sample, received the care and services in accordance with professional standards and the comprehensive care plan for Resident #102 (R102) and #105 (R105). The findings include: 1. The facility staff failed to administer a dose of Levothyroxine on 4/29/2022 to R102. On the most recent MDS (minimum data set) assessment, a Medicare admission/five day assessment, with an assessment reference date of 5/4/2022, the resident scored a 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. The physician order dated, 4/28/2022, documented Levothyroxine Sodium Tablet (Used to treat hypothyroidism [condition where the thyroid gland does not produce enough thyroid hormone]) (1) 75 MCG (micrograms); Give 1 tablet by mouth in the morning for Thyroid." The April 2022 MAR (medication administration record) documented the above order. On 4/29/2022, a "5" was documented in the box for the nurse to sign off the medication as given. The code at the bottom of the MAR documented a "5 = Hold/See Nurse Note." The nurse's note dated 4/29/2022 at 6:23 a.m. documented, "Waiting on medication from pharmacy." The comprehensive care plan dated 4/29/2022, documented in part, "(R102) is at risk for	{F 684}	4. DON/designee will conduct audits of residents' MARs to include thyroid medication and medication to treat depression 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months to ensure medications are available. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee's recommendations.	

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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
{F 684}	Continued From page 12 complications of hypothyroidism such as: intolerance to cold, decreased appetite, weight gain, dry skin, mood changes, constipation, fatigue & bradycardia R/T (related to): Dx (diagnosis) Hypothyroidism." The "Interventions" documented in part, "Administer thyroid replacement therapy as ordered." The pharmacy manifest, the delivery of the medications to the facility document, was dated 4/29/2022. The medications were delivered to the facility at 4:06 a.m. on 4/29/2022. The [Name of Automated Medication Dispensing System] documented the machine had Levothyroxine 75 MCG, quantity on hand, was documented as "9." The [Name of Automated Medication Dispensing System] documentation of all medications removed from the system between 4/21/2022 and 4/29/2022 failed to evidence documentation of Levothyroxine having been removed from the system. The nurse who failed to administer the Levothyroxine was not available for interview. An interview was conducted with LPN (licensed practical nurse) #3 on 5/11/2022 at 10:08 a.m. When asked what a nurse does if a medication is not in the medication cart at the time the medication is due, LPN #3 stated the nurse should first go to the [Name of Automated Medication Dispensing System]. LPN #3 stated if the medication is not in the [Name of Automated Medication Dispensing System], the nurse should call the pharmacy and have it sent over immediately from the local pharmacy. LPN #3	{F 684}		

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{F 684}	Continued From page 13	{F 684}		

stated that the nurse should have a conversation with the doctor or nurse practitioner throughout this process to keep them informed. The doctor/nurse practitioner may tell the nurse to hold it until available or change the medication to something else. When asked where all of the checking and conversation with the doctor/nurse practitioner is documented, LPN #3 stated it should be in the nurse's note or in an eMAR (electronic MAR) note.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 5/11/2022 at 10:13 a.m. When asked what a nurse does if a medication is not in the medication cart at the time the medication is due, RN #1 stated the nurse should first check the [Name of Automated Medication Dispensing System]. IF it's not there the nurse should call the pharmacy and have it stated (sent over immediately) from the local pharmacy. RN #1 stated the nurse should notify the doctor/nurse practitioner of what is going on. She stated the doctor/nurse practitioner may change the medication or give an order to give when it arrives. When asked where it this documented, RN #1 stated it should be in a nurse's note, eMAR note or in the skilled note.

The facility policy, "Medication Shortages/Unavailable Medications" documented in part, "2. IF a medication shortage is discovered during normal Pharmacy hours...2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the mediation from the Emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an

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{F 684}	Continued From page 14 emergency delivery...3. If the medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Mediation Supply." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were made aware of the above concern on 5/11/2022 at 12:19 p.m. No further information was provided prior to exit. 1. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682461.html. 2. The facility staff failed to administer Fluoxetine on 4/21/2022 to R105. On the most recent MDS (minimum data set) assessment, an Admission/Medicare 5 day assessment, with an assessment reference date of 4/27/2022, the resident scored a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired for making daily decisions. The physician order dated 4/20/2022, documented, "Fluoxetine HCL (hydrochloride) (used to treat depression) (1) HCL (hydrochloride) Capsule 10 MG (milligrams); Give 1 capsule via PEG - Tube (gastrointestinal tube used for feeding and medications) one time a day for	{F 684}		

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{F 684}	Continued From page 15 depression." The MAR (medication administration record) documented the above order for Fluoxetine. On 4/21/2022, the box for the scheduled dose documented a "5." The code at the bottom of the MAR documented a "5 = Hold/See Nurse Note." The nurse's note dated, 4/21/2022 at 11:46 a.m. failed to evidence documentation as to why the medication was not administered. The comprehensive care plan dated, 4/21/2022, documented in part, "Focus: (R105) is at risk for adverse reactions and side effects r/t (related to) psychotropic medication. Resident takes: Antidepressant." The "Interventions" documented in part, "Administer antidepressant medications per orders." The pharmacy manifest, the delivery of the medications to the facility document, was dated 4/21/2022. The manifest documented the medications were received at the facility on 4/21/2022 at 1:56 p.m. The [Name of Automated Medication Dispensing System] documented the machine had Fluoxetine HCL 10 MG, quantity on hand documented, "10." The [Name of Automated Medication Dispensing System] documentation of all medications removed from the system between 4/21/2022 and 4/29/2022 failed to evidence documentation of Fluoxetine having been removed from the system. The nurse who failed to administer the Fluoxetine on 4/21/2022 was not available for interview.	{F 684}		

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{F 684}	Continued From page 16 An interview was conducted with LPN (licensed practical nurse) #3 on 5/11/2022 at 10:08 a.m. When asked what a nurse does if a medication is not in the medication cart at the time the medication is due, LPN #3 stated the nurse should first go to the [Name of Automated Medication Dispensing System]. LPN #3 stated if the medication is not in the [Name of Automated Medication Dispensing System], the nurse should call the pharmacy and have it sent over immediately from the local pharmacy. LPN #3 stated that the nurse should have a conversation with the doctor or nurse practitioner throughout this process to keep them informed. The doctor/nurse practitioner may tell the nurse to hold it until available or change the medication to something else. When asked where all of the checking and conversation with the doctor/nurse practitioner is documented, LPN #3 stated it should be in the nurse's note or in an eMAR (electronic MAR) note. An interview was conducted with RN (registered nurse) #1, the unit manager, on 5/11/2022 at 10:13 a.m. When asked what a nurse does if a medication is not in the medication cart at the time the medication is due, RN #1 stated the nurse should first check the [Name of Automated Medication Dispensing System]. IF it's not there the nurse should call the pharmacy and have it stated (sent over immediately) from the local pharmacy. RN #1 stated the nurse should notify the doctor/nurse practitioner of what is going on. She stated the doctor/nurse practitioner may change the medication or give an order to give when it arrives. When asked where it this documented, RN #1 stated it should be in a nurse's note, eMAR note or in the skilled note.	{F 684}		

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{F 684}	Continued From page 17 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were made aware of the above concern on 5/11/2022 at 12:19 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a689006.html	{F 684}		
{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 - §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:	{F 812}	1. The bag of sliced cheddar cheese observed open to air was discarded. The wet mop observed in the empty bucket in the janitor closet was hung to dry. 2. Surveyor noted no other issues. Audit was also conducted and found no other issues. 3. Dietary staff will be re-educated by May 23, 2022 on the proper storage of food and the proper storage of mops by the ADM/ designee. 4. ADM/designee will conduct random audits of proper food storage and proper storage of mops, 3 times weekly times 2 weeks, weekly times 2 weeks and monthly times 2 months. A review of the findings will be taken to QAPI for 3 months to ensure compliance and will follow the committee's recommendations.	5/24/22

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{F 812}	Continued From page 18 Based on observation, staff interview, and facility document review, it was determined the facility staff failed to store food in a sanitary manner and failed to store a wet mop in a sanitary manner, in one of one kitchens. The findings include: Observation was made of the kitchen on 5/10/2022 at 10:47 a.m. accompanied by OSM (other staff member) #3, the supervisor/cook. Observation was made of a refrigerator with a bag of sliced cheddar cheese. The bag with the cheese was dated 5/9/2022 and to be used by 6/9/2022. The bag was a zip style bag and the bag was open to air. OSM #3 stated the aide must have just made sandwiches. An interview was conducted with OSM #4, the dietary aide. When asked if she had made any cheese sandwiches, OSM #4 stated she had not made any sandwiches that morning. Observation was made of the janitor closet. A wet mop was observed in the empty bucket. When asked how a mop is to be stored, OSM #3 stated it should be rinsed and hung up, it should never be left in the bucket wet. When asked why the mop shouldn't be stored wet in the bucket, OSM #3 stated it's to prevent bacteria and mold from developing. The facility policy, "Food Purchasing and Storage." documented in part, "3. Perishable Food Storage...All food items in refrigerators will be properly dated, labeled and placed in containers with lids, will be wrapped, or stored in sealed food storage bags." ASM (administrative staff member) #1, the	{F 812}		

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{F 812}	Continued From page 19 administrator, ASM #2, the director of nursing, ASM #3, the regional director of operations, and ASM #4, the regional nurse consultant, were made aware of the above concern on 5/11/2022 at 12:19 p.m. No further information was provided prior to exit.	{F 812}		