STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495311	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 5/1/23 through 5/3/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/1/2023 through 5/3/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey (VA00058477- unsubstantiated without deficiency and VA00055010- substantiated without deficiency). The Life Safety Code survey/report will follow. The census in this 75 certified bed facility was 71 at the time of the survey. The survey sample consisted of 22 current resident reviews and six closed record reviews.	F 000		5/17/23
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to assess one of 28 residents in the survey sample for self-administration of medication, Resident #41.	F 554	F 554 Resident Self-Admin Meds-Clinically Approp 1. Resident #41 was assessed for the self-administration of medications. 2. An audit of resident medication self-administration evaluation was conducted by the DON/Designee to ensure that all residents were assessed for the self-administration of medications. Continued on next page	5/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul D Levy | TITLE: ADMINISTRATOR | (X6) DATE: 5/11/23

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 554	Continued From page 1 The findings include: For Resident #41 (R41), two bottles of diabetic Tussin (1) liquid medication and two bottles of Systane (2) lubricant eye drops were observed at the bedside in R41's room unsecured. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 4/14/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. On 5/2/2023 at 10:14 a.m., an observation of R41's room was conducted. Two bottles of diabetic Tussin liquid medication were observed on a corner shelf storage rack, one four ounce bottle was observed to be unopened and one 8 ounce bottle was observed to be approximately three-quarters full. Two bottles of Systane lubricant eye drops were observed on the window sill to the right of R41's bed. Both bottles contained liquid inside. At that time, an interview was conducted with R41. When asked about the Tussin liquid medication, R41 stated that their daughter had brought the medication in and they had not taken any recently. When asked about the Systane lubricant eye drops, R41 stated that one bottle was given to them by the facility staff and they had purchased the other bottle. R41 stated that they put one drop in both eyes daily and it was effective. Additional observations of R41's room at 5/2/2023 at 2:00 p.m. revealed the two bottles of Tussin liquid medication on the corner shelf	F 554	3. LPN/RN education was provided on the resident's right to self-administer medications and completion of the resident medication self-administration evaluation. 4. An audit will be accomplished weekly x 3 months by the Director of Nursing/designee to ensure resident self-administration of medications assessment is documented within the resident record. The findings of the audit will be submitted monthly by the Director of Nursing to QAPI for review and recommendation. 5. Compliance Date: 5/17/2023	

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F 554	Continued From page 2 storage rack and two bottles of Systane lubricant eye drops on the window sill in the room. The physician orders for R41 failed to evidence an order for Systane lubricant eye drops or diabetic Tussin liquid medication or self-administration of medications. Review of R41's clinical record failed to evidence an assessment for self-administration of medications. On 5/2/2023 at approximately 2:00 p.m., a request was made to ASM (administrative staff member) #1, the executive director for evidence of a self-administration of medication assessment for R41 and the facility policy for self-administration of medications. On 5/2/2023 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident wanted to self-administer medications they notified the physician and completed an assessment to determine whether the resident was able to self-administer their medication. LPN #1 stated that they were required to observe the resident self-administering their medication to make sure they were able to perform the task and then they would put in an order for the medications that could be self-administered and left at the bedside. LPN #1 observed the two bottles of Tussin liquid medication and two bottles of Systane lubricant eye drops in R41's room and stated that they did not know if R41 was able to self-administer the medication or how it was to be stored in the room. LPN #1 stated that they typically do not lock medications up when residents self-administer medications and they thought that it would	F 554		

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F 554	Continued From page 3	F 554		

depend on the medication. LPN #1 stated that they would have to confirm with the director of nursing.

On 5/2/2023 at approximately 4:00 p.m., ASM #2, the director of nursing stated that R41 did not have a medication self-administration assessment. ASM #2 stated that R41 should not have any medications in their room and they were not able to self-administer their medications. ASM #2 stated that they had residents who self-administered medications and some stored the medications in drawers and some kept them beside them. ASM #2 stated that the storage depended on the medication.

On 5/2/2023 at approximately 4:03 p.m., ASM #1, the executive director stated that they did not have a policy regarding self-administration of medications.

On 5/2/2023 at approximately 4:05 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the assistant administrator were made aware of the concern.

No further information was presented prior to exit.

The facility policy, "Medical Care Rights in Nursing Facility" dated 12/31/2016 documented in part, "...Each Resident has the right to self-administer medications. The interdisciplinary team will determined for each Resident that this practice is clinically appropriate. Such determinations will be documented in the Resident's plan of care..."

Reference:
(1) Tussin

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F 554	Continued From page 4 Guaifenesin is used to relieve chest congestion. Guaifenesin may help control symptoms but does not treat the cause of symptoms or speed recovery. Guaifenesin is in a class of medications called expectorants. It works by thinning the mucus in the air passages to make it easier to cough up the mucus and clear the airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682494.html (2) Systane Systane is used in adults to relieve burning, irritation, and discomfort caused by dry eyes. This information was obtained from the webstie: https://www.drugs.com/mtm/systane.html	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561	**F 561 Self-Determination** 1. The agency C N A was removed from the ability to work at facility. Resident 23's choices of bedtime are followed. 2. An audit of promoting resident choice of bedtime was completed by the DON to ensure that the facility was promoting and facilitating the resident's choice in desired bedtimes. 3. C N A education was provided on promoting and facilitating the resident's choices, including desired bedtimes. Continued on next page	5/17/23

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F 561	Continued From page 5 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, it was determined that the facility failed to promote and facilitate the resident's right to self-determination by promoting resident's choice in desired bedtime for one of 28 residents in the survey sample, Resident #23. The findings included: For Resident #23, the facility staff failed to promote the resident's desired bedtime. Resident #23 was admitted to the facility on 3/14/23 with diagnosis that included but were not limited to: right lower leg fracture, DM (diabetes mellitus) and depression. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 3/20/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, transfer, walking, locomotion, dressing, eating,	F 561	4. An audit will be accomplished weekly x 3 months by the Director of Nursing/designee through resident interview to ensure promotion and facilitation of the resident's choice in desired bedtimes. The findings of the audit will be submitted monthly by the Director of Nursing to QAPI for review and recommendation. 5. Compliance Date: 5/17/23	

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F 561	Continued From page 6	F 561		

hygiene and bathing.

A review of the comprehensive care plan dated 1/3/22, which revealed, "PROBLEM: ADLs (activities of daily living) Functional Status/Rehabilitation Potential. Resident has alteration in ADL function due to weakness associated with right tibia/fibula fracture. Risk factors include impaired mobility, muscle weakness and NWB (non-weight bearing) status. APPROACH: Allow me choices regarding my preference with where I would like to eat, picking out clothing, taking baths/showers and how I would like to accept my medications. Assist with turning and repositioning on rounds and as needed."

A review of the ADL form dated 4/30/23 at 7:00 PM, revealed, "How did resident transfer? Activity did not occur." No other documentation on the ADL form for evening shift on 4/30/23.

An interview was conducted with Resident #23 on 5/1/23 at 11:01 AM. Resident #23 stated, "It took almost three hours for me to be able to get in bed on April 30th. I started calling every 15 minutes beginning at 9:00 PM till close to 12:00 AM when the night aide put me to bed. The evening aide would come into the room and shut off the light and tell me she would be back and never returned."

Resident #23 was asked to push the call button which revealed it was functioning, and a nurse answered. When asked how the call system functioned, LPN (licensed practical nurse) #1 stated, the call bells go to the call bell phone that the CNAs (certified nursing assistant) carry.

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F 561	Continued From page 7 An interview was conducted on 5/1/23 at 2:45 PM with ASM (administrative staff member) #2, the director of nursing. When asked if she had been informed of the delay in getting Resident #23 into bed on evening shift 4/30/23, ASM #2 stated, yes, the executive director spoke with the daughter. This was an agency CNA and there will not be any agency CNAs assigned to Resident #23. An interview was conducted on 5/2/23 at 8:50 AM with Resident #23, when asked how their evening went, Resident #23 stated, "It was great, they put me to bed when I wanted to go." On 5/2/23 at approximately 4:00 PM, ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the assistant administrator was made aware of the findings. On 5/3/23 at 9:15 AM, ASM #2, the director of nursing stated, in regard to the CNA with this resident, "I have tried to contact her and she has not called me back, I called her agency and she still has not responded. Since she cannot be bothered to return my calls, she will not be back." According to the facility's policy "Medical Care Rights in a Nursing Facility" dated 12/2016, revealed, "The Resident has the right to be fully informed in language that he or she can understand of his/her total health status, including but not limited to, his/her medical condition. The Resident has the right to refuse treatment and to refuse to participate in experimental research, and also the right to request treatment and/or discontinue treatment. Moreover, the Resident has the right to: Choose a personal attending physician; Be fully informed in advance about care and treatment, type of professional	F 561		

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F 561	Continued From page 8 delivering care, risks and benefits of treatment and options, and of any changes in that care of treatment that may affect the Resident's well-being, and; insofar as possible, the Facility will assist Residents to use their preferred health care providers and to participate in planning their programs of care and services while in the Facility, and will respect each Resident's decision about accepting or refusing medical care." No further information was provided prior to exit.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 28 residents in the survey sample, Resident #29. The findings include: For Resident #29 (R29), the facility staff failed to code the quarterly MDS assessment with an ARD (assessment reference date) of 2/27/2023 for hospice services received during the assessment period. Review of the clinical record for R29 revealed the most recent MDS assessment to be a quarterly MDS with an ARD of 2/27/2023. Section O of the assessment failed to document R29 receiving hospice services during the assessment period.	F 641	**F 641 Accuracy of Assessments** 1. Resident #29's MDS assessment was corrected to reflect the reception of hospice services. 2. An audit of residents receiving hospice services was completed by the MDS Director to ensure that the MDS assessment accurately reflected the resident's reception of hospice services. 3. The MDS coordinator was provided education on the accuracy of the resident MDS assessment. 4. An Audit will be completed by the Administrator/designee monthly x three months to ensure the MDS assessment is accurately reflects the resident's current level of care. The findings of the audit will be submitted by the Administrator/Designee to QAPI for review and recommendation. 5. Compliance Date: 5/17/23	5/17/23

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F 641	Continued From page 9 The physician orders for R29 documented in part, "Admit to [Name of hospice] for Alzheimer's disease. Order Date: 11/24/2022." The comprehensive care plan for R29 failed to evidence a care plan related to hospice services. On 5/2/2023 at 1:45 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they used the RAI (resident assessment instrument) manual when completing the MDS assessments. RN #2 reviewed R29's quarterly MDS assessment with the ARD of 2/27/2023 and stated that it looked like it was not coded for hospice services. RN #2 stated that R29 was receiving hospice services during the assessment period and that it should have been marked on the assessment. According to the RAI Manual, Version 1.16, dated October 2018, section O0100 documented in the steps for assessment, "1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days...O0100K, Hospice Care, Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider..." On 5/2/2023 at 4:03 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the assistant administrator were made aware of the concern.	F 641		

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F 641	Continued From page 10 No further information was provided prior to exit.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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). (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	F 656	**F 656 Develop/Implement Comprehensive Care Plan** 1. Resident # 29's comprehensive care plan was developed to include the reception of hospice services. 2. An audit of comprehensive care plans was conducted by the MDS Director to ensure that the comprehensive care plan reflected the residents' current level of care. 3. The Nursing team and MDS Coordinator were educated on developing an accurate care plan to reflect the residents' current level of care. 4. An audit will be completed weekly x 3 months by the Administrator/designee to ensure the comprehensive care plan has been developed and implemented to accurately reflect the residents' current level of care. The findings of the audit will be submitted monthly by the Administrator/Designee to QAPI for review and recommendation. 5. Compliance Date: 5/17/23	5/17/23

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F 656	Continued From page 11 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to develop the comprehensive care plan for one of 28 residents in the survey sample, Resident #29. The findings include: For Resident #29 (R29), the facility staff failed to develop the comprehensive care plan to include hospice services. Review of the clinical record for R29 revealed the most recent MDS assessment to be a quarterly MDS with an ARD of 2/27/2023. Section O of the assessment failed to document R29 receiving hospice services during the assessment period. The physician orders for R29 documented in part, "Admit to [Name of hospice] for Alzheimer's disease. Order Date: 11/24/2022." Review of the comprehensive care plan for R29 failed to evidence a care plan related to hospice services.	F 656		

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The progress notes for R29 documented in part, "2/13/2023 3:21 p.m. Resident currently on hospice, denies pain or discomfort at this time. Will continue to monitor and treat per provider orders." The progress notes further documented, "2/27/2023 10:45 a.m. MDS Quarterly - (Name of R29) is a LTC (long term care) resident receiving hospice care for Alzheimer's dementia..."

On 5/2/2023 at 1:45 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they completed the comprehensive care plans for residents and updated them quarterly. RN #2 stated that the care plans were updated based on the MDS schedule based on the reviews and the areas that triggered from the assessment. RN #2 reviewed R29's comprehensive care plan and stated that they did not have a care plan for hospice and there should be one in place.

On 5/2/2023 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to let the staff know what care the resident needed. LPN #1 stated that hospice services should be addressed on the residents care plan.

On 5/2/2023 at 4:03 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the assistant administrator were made aware of the concern.

No further information was provided prior to exit.

The facility policy, "Comprehensive Person-Centered Care Planning" dated 11/15/2017 documented in part, "...Each resident's comprehensive care plan will describe

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F 656	Continued From page 13 the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being..."	F 656		
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 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, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to secure medications in resident	F 761	**F 761 Label/Store Drugs and Biologicals** 1. The two bottles of diabetic Tussin and two bottles of Systane eye drops were removed from resident # 41's room. Resident #35's was provided a secure lockbox for the Albuterol inhaler and provided return demonstration for locking and unlocking. 2. A 100% audit was conducted by the Director of Nursing to ensure that no medications were unsecured within resident rooms. 3. LPN/RN education was provided on properly securing medications within resident rooms. 4. An audit will be completed weekly x 3 months by the Director of Nursing/designee to ensure no medications are unsecured within resident rooms. The findings of the audit will be submitted monthly by the Administrator/Designee to QAPI for review and recommendation. 5. Compliance Date: 5/17/23	5/17/23

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F 761	Continued From page 14 rooms for two of 28 residents in the survey sample, Resident #41 and Resident #35. The findings include: 1. For Resident #41 (R41), the facility staff failed to secure two bottles of diabetic Tussin (1) liquid medication and two bottles of Systane (2) lubricant eye drops were observed at the bedside in R41's room unsecured. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 4/14/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. On 5/2/2023 at 10:14 a.m., an observation of R41's room was conducted. Two bottles of diabetic Tussin liquid medication were observed on a corner shelf storage rack, one four ounce bottle was observed to be unopened and one 8 ounce bottle was observed to be approximately three-quarters full. Two bottles of Systane lubricant eye drops were observed on the window sill to the right of R41's bed. Both bottles contained liquid inside. At that time, an interview was conducted with R41. When asked about the Tussin liquid medication, R41 stated that their daughter had brought the medication in and they had not taken any recently. When asked about the Systane lubricant eye drops, R41 stated that one bottle was given to them by the facility staff and they had purchased the other bottle. R41 stated that they put one drop in both eyes daily they were effective.	F 761		

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Additional observations of R41's room at 5/2/2023 at 2:00 p.m. revealed the two bottles of Tussin liquid medication on the corner shelf storage rack and two bottles of Systane lubricant eye drops on the window sill in the room.

The physician orders for R41 failed to evidence an order for Systane lubricant eye drops or diabetic Tussin liquid medication or self-administration of medications.

On 5/2/2023 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they were required to observe the resident self-administering their medication to make sure they were able to perform the task and then they would put in an order for the medications that could be self-administered and left at the bedside. LPN #1 observed the two bottles of Tussin liquid medication and two bottles of Systane lubricant eye drops in R41's room and stated that they did not know if R41 was able to self-administer the medication or how it was to be stored in the room. LPN #1 stated that they typically do not lock medications up when residents self-administer medications and they thought that it would depend on the medication. LPN #1 stated that they would have to confirm with the director of nursing.

On 5/2/2023 at approximately 4:00 p.m., ASM (administrative staff member) #2, the director of nursing stated that R41 did not have a medication self-administration assessment. ASM #2 stated that R41 should not have any medications in their room and they were not able to self-administer their medications. ASM #2 stated that they had residents who self-administered medications and some stored the medications in drawers and

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F 761	Continued From page 16 some kept them beside them. ASM #2 stated that the storage depended on the medication. On 5/2/2023 at approximately 4:05 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the assistant administrator were made aware of the concern. No further information was presented prior to exit. The facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 12/01/07 documented in part, "...13. Bedside Medication Storage: 13.1 Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and Facility administration. 13.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room..." Reference: (1) Tussin Guaifenesin is used to relieve chest congestion. Guaifenesin may help control symptoms but does not treat the cause of symptoms or speed recovery. Guaifenesin is in a class of medications called expectorants. It works by thinning the mucus in the air passages to make it easier to cough up the mucus and clear the airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682494.html (2) Systane Systane is used in adults to relieve burning, irritation, and discomfort caused by dry eyes. This information was obtained from the webstie: https://www.drugs.com/mtm/systane.html	F 761		

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F 761	Continued From page 17 2. For Resident #35 (R35), the facility staff failed to secure an Albuterol inhaler (1) that was observed at the bedside in R35's room. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/2023, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 5/1/2023 at 11:50 a.m., an observation of R35's room was conducted. An Albuterol inhaler was observed on R35's nightstand to the left of the bed, unsecured. A spacer (2) was observed to be attached to the inhaler. At that time, an interview was conducted with R35. When asked about the Albuterol inhaler, R35 stated that they kept the inhaler at their bedside to use when they had "coughing spells" and used it as needed. R35 stated that it had been "a couple of days" since they had used the inhaler. Additional observations of R35's room at 5/1/2023 at 2:10 p.m. and 5/2/2023 at 10:30 a.m., revealed the Albuterol inhaler on the nightstand to the left of the bed unsecured. The physician orders for R35 documented in part, "albuterol sulfate HFA aerosol inhaler; 90 mcg (micrograms)/actuation; amt (amount): 2 puffs; inhalation; Every 6 Hours - PRN (as needed); dx: wheezing/sob (shortness of breath) *NEEDS HELP TO self administer and keep @ bedside*; Order Date: 03/23/2023..." The "Self-Administration of Medication" assessment for R35 dated 9/28/2022	F 761		

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documented in part, "...List of medications resident would like to self-administer. Albuterol inhaler...Based on answers, is it appropriate for resident to self-administer any medications? Yes...Where will self-administered medications be stored? Resident Room..."

On 5/2/2023 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that R35 was able to self-administer the Albuterol inhaler and kept it at their bedside in the room. LPN #1 stated that they typically do not lock medications up when residents self-administer them and they thought that it would depend on the medication. LPN #1 stated that they would have to confirm with the director of nursing.

On 5/2/2023 at approximately 4:00 p.m., ASM (administrative staff member) #2, the director of nursing stated that they had residents who self-administered medications and some stored the medications in drawers and some kept them beside them. ASM #2 stated that the storage depended on the medication.

On 5/2/2023 at approximately 4:05 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the assistant administrator were made aware of the concern.

No further information was presented prior to exit.

Reference:
(1) Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases

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F 761	Continued From page 19 that affect the lungs and airways). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682145.html (2) If you use your inhaler the wrong way, less medicine gets to your lungs. A spacer device will help. The spacer connects to the mouthpiece. The inhaled medicine goes into the spacer tube first. Then you take two deep breaths to get the medicine into your lungs. Using a spacer wastes a lot less medicine than spraying the medicine into your mouth. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000042.htm	F 761		