STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255333	A. BUILDING _____ B. WING _____	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGE REGIONAL HEALTH & REHAB CENTER	859 WINTER ST LUCEDALE, MS 39452

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 12/18/2023 through 12/20/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F623, F641, F656, F658, F677, F761, F812, and F867. The facility had a census of 43 and was licensed for 59 beds.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		1/12/24

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

Electronically Signed | 01/09/2024

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 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to provide the resident, or the Resident Representative (RR), written notification of a hospital transfer at the time of transfer for three (3) of three (3) sampled residents reviewed for hospitalization. Resident #8, Resident #22, and Resident #24.	F 623	1.Immediate action(s) taken for the resident(s) found to have been affected include: Resident Numbers 8, 22 and 24 were provided the reason for transfer/discharge in writing by the Business Office Manager on December 22, 2023. The State Long-Term Care Ombudsman was	

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F 623	Continued From page 3 Findings Include: Review of the facility's, "Transfer or Discharge Notice" revised December 2016 revealed Policy Statement: Our facility shall provide a resident and or the residents representative (sponsor) with a thirty (30)-day written notice of impending transfer or discharge. Policy Interpretation and Implementation: 1. A resident and or his or her representative (sponsor) will be given 30-day advance notice of an impending transfer or discharge from our facility. 2. Under the following circumstances the notice will be given as soon as it is practicable but before transfer or discharge. .... 3. The resident and or representative (sponsor) will be notified in writing of the following information: a. the reason for the reason of transfer or discharge. b. the effective date of transfer or discharge; c. The location to which the resident is being transferred ..." Resident #8 A record review of Resident #8's Face Sheet revealed an admission date of 06/09/22 with diagnoses that included End stage renal disease. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 09/16/23 revealed Resident #8 was discharged to an Acute Hospital on 9/16/23. Review of the medical record revealed there was no written notification of the hospital transfer to the resident, or the RR provided on 9/16/23. Resident #22 A record review of the "Face Sheet" revealed the	F 623	notified via monthly listing sent on October 3, 2023 and December 7, 2023. Resident Numbers 8, 22, and 24□s representatives were also notified and given a copy of the notice on December 22, 2023. 2.Identification of other residents having the potential to be affected was accomplished by: On December 22,2023 the Business Office Manager performed an audit on transfer/discharge charts from January 1, 2023 through December 22, 2023. The Business Office Manager determined that all residents who have been transferred or discharged have the potential to be affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: The Notice of Requirements for Transfer/Discharge policy was updated on December 22, 2023. On December 22, 2023 the Nursing Home Administrator conducted in-servicing with the Business Office Manager (BOM) and the Social Services Coordinator (SSC) on the Transfer/Discharge Policy and regulation. On December 27, 2023 and December 29, 2023 the Nursing Home Administrator conducted in-servicing with the Nursing staff on the Transfer/Discharge Policy and regulation. The incident of Resident Numbers 8, 22, and 24 were taken to the Quality Assurance (QA) Committee on January 5, 2024. 4.The following corrective action(s) will be	

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F 623	Continued From page 4 facility admitted Resident #22 on 10/12/16 with a diagnoses that included Rhabdomyolysis and Retention of urine, unspecified. A record review of the Discharge MDS with an ARD of 11/7/23 revealed Resident #22 was discharged to an Acute Hospital on 11/7/23. Review of the medical record revealed there was no written notification of the hospital transfer to the resident, or the RR provided on 11/7/23. Resident #24 A record Review of the "Face Sheet" revealed the facility admitted Resident #24 on 7/8/22 with a diagnosis of Heart Disease. A record review of the Discharge MDS with an ARD of 11/24/2023 revealed Resident #24 was discharged to a Short-Term General Hospital on 11/24/23. Review of the medical record revealed there was no written notification of the hospital transfer to the resident, or the RR provided on 11/24/23. During an interview on 12/19/23 at 10:10 AM, with the Social Services Coordinator (SSC), she confirmed she did not provide written notification of transfer to the resident or the RR and that she only sent notification to the ombudsman. During an interview on 12/19/23 at 10:29 AM with the Business Office Manager (BOM), she stated that she did not provide written notification of resident transfers to the resident or their RR. In an interview on 12/20/23 at 11:31 AM, with the	F 623	monitored to ensure the practice will not reoccur: Beginning on December 22, 2023 the Business Office Manager began a weekly audit of all records of resident having a transfer of discharge during the week of the audit to ensure a copy of the transfer/discharge notice was provided. Weekly, for a period of twelve weeks, the Business Office Manager will conduct an audit and log her findings of all residents being transferred or discharged from the facility to ensure the record includes a copy of the transfer/discharge notice. Beginning on December 22, 2023 the SSC will audit the logs weekly for twelve weeks. Findings of this audit will be discussed at weekly Quality and Performance Improvement (QAP)I meetings beginning on December 22, 2023 for twelve weeks. This plan of correction will be monitored quarterly at the quarterly Quality Assurance (QA) meetings for one year starting on January 12 2023. The SSC will continue to send monthly lists to the State Long-Term Care Ombudsman. 5.Corrective Action completion date January 12, 2024. the Corrective Action Plan will be completed.	

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F 623	Continued From page 5 Director of Nursing (DON), she said she was not responsible for written transfer notifications to the family representatives. She stated the nurses call the families at the time of the transfer to explain the reason for the transfer, but the SSC was responsible for providing the written notification. During an interview on 12/15/23 at 11:47 AM, with the Administrator, she confirmed written hospital transfer notifications had not been provided to the resident or the representatives because there was a break in communication within the facility. The Administrator also confirmed she did not inform the staff who was responsible for providing the written notification of transfer to the resident or the RR, and they all thought a phone call met the compliance guidance.	F 623		
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 interview, record review and facility policy review, the facility failed to complete the Discharge Minimum Data Set (MDS) assessments for one (1) of 16 residents sampled. Resident # 6 Findings Include: A review of the facility's policy titled, "MDS 3.0 Completion," reviewed/revised 10/02/23, revealed, "Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an	F 641	1.Immediate action(s) taken for the resident(s) found to have been affected include: Resident #6 medical record was reassessed on December 22, 2023 to include the completion of a Discharge Minimum Date Set (MDS). 2.Identification of other residents having the potential to be affected was accomplished by: On 12/22/202, the MDS nurse performed an audit of all residents discharged from	1/12/24

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F 641	Continued From page 6 interdisciplinary care plan... Policy Explanation and Compliance Guidelines: 2f. Discharge Assessment - completed using the discharge date as the ARD (Assessment Reference Date). Must be completed within 14 days of the discharge date/ARD..." A record review of the facility's "Face Sheet," revealed the facility admitted Resident #6 on 07/20/23, with diagnoses that included Essential Hypertension. A record review of the facility's "Discharge Summary," for Resident #6, revealed the facility discharged the resident to home on 09/15/23. A record review of the MDS, for Resident #6, revealed there was no Discharge Assessment completed. On 12/18/2023 at 12:13 PM, an interview with Licensed Practical Nurse (LPN) #1, revealed the nurse acknowledged her failure to complete a Discharge MDS assessment for Resident #6. LPN #1 stated it was her mistake and occurred due to an oversight. LPN #1 acknowledged the lapse in the Discharge MDS completion compromises communication related to resident care. On 12/19/23 at 8:32 AM, an interview with the Director of Nurses (DON), revealed she acknowledged the facility's failure in completing the Discharge MDS assessments for the Resident #6. The DON revealed she expects the facility to put "bullet proof measures" in place to prevent this from happening again, as the MDS is a significant piece of the puzzle in resident care. The DON stated she will provide more training	F 641	December 1, 2022 through December 22,2023. The audit revealed that all residents discharged had the potential of being affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: A one-on-one in-service was conducted on December 22, 2023 by the Administrator to the Director of Nursing and the MDS Coordinator addressing the importance of completing discharge assessments within 14 days of the Assessment Reference Date (ARD). The incident of Resident #6 was taken to the Quality Assurance (QA) Committee on January 5, 2024. 4. The following corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning on December 22, 2023 weekly, for twelve weeks, the MDS Coordinator will conduct an audit log of all residents who have discharged from the facility to ensure all MDS assessments have been completed within the ARD time frame. Beginning on December 22, 2023, the Director of Nursing will audit the logs weekly, for twelve weeks. Beginning on December 22, 2023, findings of this audit will be discussed at weekly Quality Assurance and Performance Improvement (QAPI) meetings for twelve weeks. Beginning on January 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) meetings for three months.	

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F 641	Continued From page 7 opportunities for the MDS nurse and visual oversight of the process. On 12/19/23 at 9:50 AM, during an interview with the Administrator, she acknowledged the facility's failure in completing the discharge MDS assessment for the resident. The Administrator reported this is a learning process and she will work with her staff with additional training as needed.	F 641	5.Completion Date for Citation: Corrective action completion date January 12, 2024	
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	F 656		1/12/24

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F 656	Continued From page 8 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. §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 observation, interviews, record review, and facility policy review, the facility failed develop a comprehensive care plan for a resident (Resident #21) who had an indwelling catheter and failed to implement comprehensive care plan interventions for medication administration (Resident #21) and toenail care (Resident #34) for two (2) of 16 resident care plans reviewed. Findings Include: Review of the facility's policy "Care Plans, Comprehensive Person-Centered", revised December 2016, revealed, " ...A comprehensive, person-centered care plan that includes measurable objectives and timelines to meet the resident's physical, psychosocial and functional needs is developed and implemented for each	F 656	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Care Plan Nurse reviewed and updated resident number (#) 21 plan of care to include the care for an indwelling catheter on 12/22/2023. On 12/18/2023 the Charge Nurse assessed resident #21 pulse and blood pressure with her finding to be within normal limits. The Care Plan Nurse reviewed and updated the plan of care for resident #31 to include person-centered care. On 12/18/2023 the Director of Nursing trimmed resident #31 toenails. 2.Identification of other residents having the potential to be affected was	

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F 656	Continued From page 9 resident ...Policy Interpretation and Implementation ...8. The comprehensive, person-centered care plan will ...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...13 ...care plans are revised as information about the residents and the residents' conditions change ..." Resident #21 Record review of the Comprehensive Care Plan for Resident #21 revealed there was no care plan developed regarding an indwelling catheter. Further review revealed a care plan start date of 11/30/22, with a "Care Plan Goal" of "(Proper Name of Resident #21) will have no acute hypertensive episodes thru next review date", and an intervention of "Metoprolol tartrate per PCP (Primary Care Physician) Orders*Hold for HR (Heart Rate) less than 60 BPM (Beats Per Minute) ..." On 12/18/23 at 11:58 AM, during an observation, Resident #21 was lying in bed and there was an indwelling catheter drainage bag attached to the side of the bed. Record review of the "Physician's Orders revealed there was an order, dated 12/15/23 "Insert ...Foley (type of indwelling urinary catheter) cath (catheter) leave for 7 days ..." Record review of the medical record revealed there was not a care plan developed for Resident #21's indwelling urinary catheter. During an observation on 12/18/23 at 4:24 PM,	F 656	accomplished by: On 12/22/2023 The treatment nurse performed an audit identifying all residents with an indwelling catheter. This audit identified that all resident having an indwelling catheter have the potential to be affected. On 12/22/2023 the Director of Nursing and the Treatment Nurse performed a nail audit on all residents dependent upon staff for nail care. All residents' dependent upon staff for nail care have been identified to have the potential to be affected. On December 22, 2023 the charge nurse performed an audit identifying all residents with a physician order, requiring a pulse obtained prior to a medication administration. This audit revealed that all resident requiring a pulse check prior to a medication administration have the potential of being affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: On December 22, 2023, the Director of Nursing in-serviced the Care Plan Nurse one-on-one about the importance of following the facility s policy on Comprehensive Care Plans.The Director of nusring inserviced all interdisciplinary care plan team members responsible for writing care plans on the facility s policy and procedure for developing Comprehensive Care Plans on December 27th and December 29th, 2023. The incidents of Resident #21 and #32 were taken to the Quality Assurance (QA) Committee on January 5, 2024.	

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F 656	Continued From page 10 Licensed Practical Nurse (LPN) #2 administered Metoprolol Tartrate and did not obtain the resident's pulse prior to administering the medication. Record review of the "Physician Orders", for the month of December 2023, revealed Resident #21 had a Physician's Order, dated 11/21/23 for "Metoprolol Tartrate 25 MG (Milligrams) ...Give ½ tab (tablet) to equal 12.5 MG PO (by mouth)/Per PEG BID (two times daily) ...Obtain and record pulse before admin (administering) hold if less than 60 ... Record review of the "Face Sheet" revealed the facility admitted Resident #21 on 9/27/19 and she had a diagnosis of Essential Hypertension. Resident #34 A record review of the Comprehensive Care Plan revealed a care plan, dated 11/2/22, with a Care Plan Description "(Proper Name of Resident #34) is at risk for skin breakdown... Intervention ...Observe skin during routine ADL (Activities of Daily Living) care and report any abnormal to nurse. Perform weekly body, fingernails, and toenails audit." During an interview and observation on 12/18/23 at 11:09 AM, Resident #34 had long, thick toenails. Resident #34 explained that her toenails needed to be clipped and she was unable to do it herself because she had arthritis, and the nails were too thick. A record review of the "Face Sheet" revealed the facility admitted Resident #34 on 05/11/20 with diagnoses including Type 2 Diabetes Mellitus,	F 656	4.The following corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning on Dec 22, 2023 a selection of five care plans will be reviewed weekly for twelve weeks by the Care Plan Nurse to ensure all Physician Orders are recorded on the care plan. The Care Plan nurse will maintain a log of his/her findings for twelve weeks. Beginning on December 22,2023 Medical Records will audit these logs weekly for twelve weeks. Beginning on December 22, 2023 findings of this audit will be discussed at weekly Quality Assurance and Performance (QAPI) meetings for twelve weeks. Beginning on January 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) meetings for three months. 5. Completion Date of Correction Action Plan: Corrective Action completion date January 12, 2024	

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F 656	Continued From page 11	F 656		

Unspecified Osteoarthritis, and Age-related Physical Debility.

A record review of the "Physician Orders" for the month of December 2023, revealed Resident #34 had a Physician's Order, dated 11/20/23, for "Weekly toenail audit on body audit day N= toenails do not need to be trimmed Y=request form for NP (Nurse Practitioner) to evaluate toenails on next visit ..."

A record review of the electronic Treatment Administration Record (eTAR), for the month of December 2023 for Resident #34, revealed facility staff recorded "N" (toenails do not need to be trimmed) on 12/04/23, 12/11/23, and 12/18/23.

On 12/20/23 at 10:38 AM, in an interview with Licensed Practical Nurse (LPN) #4, he stated that care plans should be developed when there is a new Physician's Order and confirmed there was no care plan developed for Resident #21's indwelling catheter. He stated the care plan is used by the nurses and Certified Nursing Assistant to provide optimal care.

During an interview on 12/20/23 at 10:50 AM, with LPN #5/Wound Care Nurse, she explained she she only observed the toenails, but she did not touch them. LPN #5 confirmed that she did not document that Resident #34 had long thick toenails, nor did she tell a Registered Nurse (RN) that the toenails were long and thick and needed to be trimmed.

On 12/20/23 at 1:20 PM, during an interview with the Administrator, she explained she expected staff to follow each resident centered care plan to provide care for the residents.

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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, staff interview, record review, and facility policy review, the facility failed to follow a physician's order to obtain a resident's pulse before administering an antihypertensive medication for one (1) of four (4) medication administration observations. Resident #21 Findings Include: Review of the facility's policy, "Medication Administration", with a revision date of 2/2023, revealed " Policy: Medications are administered by licensed nurses ...in accordance with professional standards of practice ...Policy Explanation and Compliance Guidelines ...8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters ...Example guidelines for Medication Administration ...Medication requiring vital signs prior to administration ...Anti-Hypertensives ..." On 12/18/23 at 4:24 PM, in an observation of medication administration, Licensed Practical Nurse (LPN) #2 administered Metoprolol Tartrate and did not obtain the resident's pulse prior to administering the medication.	F 658	1.Immediate action(s) taken for the resident(s) found to have been affected include: Resident #21 was assessed immediately by the Charge Nurse on December 18, 2023 to find that the pulse and blood pressure were within normal limits. 2. Identification of other residents having the potential to be affected was accomplished by: On 12/22/2023 the Charge Nurse conducted an audit of all residents having a physician order to have a pule check prior to hypertensive medication administration, Her finding identified the residents requiring a pulse check prior to administering hypertensive medications have the potential for being affected. 3Actions taken/systems put into place to reduce the risk of future occurrence include: On December 22, 2023 the Staff Development Nurse provided in-servicing to LPN #2 on following Physician Orders during Medication Administration. On December 27th and December 29, 2023 all Nurses were in-serviced by the Staff Development Nurse on following	1/12/24

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F 658	Continued From page 13 Record review of the "Physician Orders", for the month of December 2023, revealed Resident #21 had a Physician's Order, dated 11/21/23 for "Metoprolol Tartrate 25 MG (Milligrams) ...Give ½ tab (tablet) to equal 12.5 MG PO (by mouth)/Per PEG (Percutaneous Endoscopic Gastrostomy) BID (two times daily) ...Obtain and record pulse before admin (administering) hold if less than 60 ..." On 12/18/23 at 4:31 PM, in an interview with LPN #2, she confirmed that she did not check Resident #21's pulse before she administered Metoprolol Tartrate. She stated she should have checked the resident's pulse because the medication can cause a decreased heart rate. On 12/20/23 at 3:10 PM, in an interview with the Director of Nursing (DON), she confirmed that LPN #2 should have checked the resident's pulse before giving Metoprolol Tartrate because that medication can cause the resident's heart rate to drop. She stated LPN #2 did not follow the Physician Orders related to administering the medication. Record review of the "Face Sheet" revealed the facility admitted Resident #21 on 9/27/19 with diagnoses that included Essential Hypertension.	F 658	Physician Orders during Medication Administration. On December 22, 2023 the incident of Resident #21 was taken to the Quality Assurance and Performance Improvement meeting (QAPI). This incident will be taken to the weekly QAPI meeting for 12 weeks. Beginning on January 12, 2024 the incident of Resident #21 will be taken to the quarterly Quality Assurance (QA) meetings for three months. 4The following corrective action(s) will be monitored to ensure the practice will not reoccur: Begiining December 22, 2023 weekly for a period of twelve weeks, the Staff Development Nurse will monitor a med-pass on five residents who are ordered for a pulse check by the physician prior to medication administration. The Staff Development Nurse will maintain a log of her findings. Beginning December 22, 2023,the Director of Nursing will audit these logs weekly, for twelve weeks. Beginning December 22, 2023 findings of this audit will be discussed at the weekly Quality and Performance Improvement (QAPI) meetings, for twelve weeks. Beginning on January 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) meeting for three months. 5Correction Action Completion Date The corrective Action completion date is January 12, 2024.	
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		1/12/24

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F 677	Continued From page 14 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and the facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for a resident who was dependent upon staff for toenail care for one (1) of two (2) residents reviewed for ADL care. Resident #34 Findings include: Review of the facility's policy "Activities of Daily Living (ADLs), Supporting", revised 1/12/2021, revealed "Policy Statement ... Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene ...Policy Interpretation and Implementation ...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently ...including appropriate support with: a. Hygiene (bathing, dressing, grooming) ..." Review of the facility's policy "Fingernails/Toenails, Care of", revised 02/2018, revealed " ...Purpose: The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections ... General Guidelines 1. Nail care includes daily cleaning and regular trimming ... 6. Stop and report to the nurse supervisor if ... if nails are too hard or too thick to cut with ease ... Documentation The	F 677	1.Immediate action(s) taken for the resident(s) found to have been affected include: Nail care was provided for resident #34 on December 19, 2023. The Director of Nursing and the treatment nurse completed an assessment of each residents nails on December 22, 2023. Residents refusing nail care will be care planned with the refusal documented in the resident□s medical record. 2.Identification of other residents having the potential to be affected was accomplished by: On Dec 22, 2023 the Director of Nursing and the Treatment Nurse completed a nail audit on all resident□s dependent on staff for nail care. Finding from this assessment revealed that all resident□s dependent on staff for nail care have the potential to be affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service was conducted by the Director of Nursing to the treatment nurse and all direct care staff addressing the proper care of nails including resident□s preference, the refusal of care, and high	

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F 677	Continued From page 15 following information should be recorded in the resident's medical record: 1. The date and time that nail care was given ..." On 12/18/23 at 11:09 AM, during an interview and observation, Resident #34 had long, thick toenails. Resident #34 explained that her toenails needed to be clipped and she was unable to do it herself because she had arthritis, and the nails were too thick. On 12/19/23 at 8:55 AM, during an interview and observation with Resident #34, her toenails remained long and untrimmed. She reported they were so long that they would get caught on her socks and bed linens. She expressed that she could not clip them herself and would like to have them trimmed. On 12/19/23 at 9:45 AM, during an interview with Certified Nurse Aide (CNA) #3, she explained that Resident #34 was very independent with ADLs but was unsure if the resident preferred to keep her toenails long. She explained the CNAs completed nail care, including clipping the nails, if the resident did not have a diagnosis of Diabetes Mellitus (DM). If the resident had DM, then a Registered Nurse (RN) had to clip or trim the nails. On 12/19/23 at 11:30 AM, during an interview with the Director of Nursing (DON), she explained that a podiatrist visited the facility every three (3) months and tried to see all the residents. The last time the podiatrist visited the facility was on 10/25/23. The RNs were responsible for clipping the toenails in-between the time of podiatrist visits. The facility also had a treatment nurse on weekends that clipped resident nails as needed.	F 677	risk conditions on December 27 and December 29, 2023. The incident of Resident #34 was taken to the Quality Assurance (QA) Committee on January 5, 2024. This incident will be brought before the QA Committee again on January 17, 2024. 4.The following corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning on Dec 22, 2023The treatment nurse will review nail care for ten residents out of the census weekly for twelve consecutive weeks to ensure nail care is provided for all dependent residents. The treatment nurse will make a log of her findings, and she will report them to the Director of Nursing. Beginning on December 22, 2023 the Director of Nursing will audit the logs weekly for twelve weeks. Beginning on December 22, 2023 findings of this audit will be discussed at weekly Quality Assurance and Performance Improvement (QAPI) meetings for twelve weeks. Beginning on January 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) meeting for three months. 5. Corrective Action Plan Completion date: Corrective Action Completion Date January 12, 2024.	

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F 677	Continued From page 16	F 677		

A record review of the "Physician Orders" for the month of December 2023, revealed Resident #34 had a Physician's Order, dated 11/20/23, for "Weekly toenail audit on body audit day N= toenails do not need to be trimmed Y=request form for NP (Nurse Practitioner) to evaluate toenails on next visit ..."

A record review of the electronic Treatment Administration Record (eTAR), for the month of December 2023 for Resident #34, revealed facility staff recorded "N" (toenails do not need to be trimmed) on 12/04/23, 12/11/23, and 12/18/23.

On 12/20/23 at 10:50 AM, during an interview with Licensed Practical Nurse (LPN) #5/Wound Care Nurse, she explained she completed the weekly body audits for Resident #34 and the resident's toenails were part of the body audit. She stated that she only observed the toenails, but she did not touch them and does not know the purpose of the toenails being on the body audit. She confirmed Resident #34's toenails were long and had been long for some time. She stated that she charted "no trim" because she was not responsible for trimming them. LPN #5 also confirmed that she did not document that Resident #34 had long toenails, nor did she tell a RN that the toenails were long and needed to be trimmed.

On 12/20/23 at 11:20 AM, during an interview with the DON and Resident #34, the DON observed Resident #34's toenails and confirmed the resident's toenails were long and thick. Resident #34 stated that her toenails needed to be clipped. The DON stated that she expected the RNs to clip resident toenails if needed. She also stated

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F 677	Continued From page 17 that she expected the wound care nurse to notify a RN if any resident's toenails needed to be clipped. A record review of the "Face Sheet" revealed the facility admitted Resident #34 on 05/11/20 with diagnoses including Type 2 Diabetes Mellitus, Unspecified Osteoarthritis, and Age-related Physical Debility. A record review of the Quarterly Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 11/01/23 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 677		
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	F 761		1/12/24

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F 761	Continued From page 18 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review the failed to ensure multidose insulin pens were dated when opened for six (6) of 19 diabetic residents who are prescribed multidose insulin pens. Findings Include: Review of the facility's policy, "Labeling of Medication Containers", revised 4/2007, revealed, " Policy Statement ...All medications maintained in the facility shall be properly labeled in accordance with the current state and federal regulations ...Policy Interpretation and Implementation ...3. Labels for individual drug containers shall include all necessary information, such as ...h. The expiration date when applicable; ..." On 12/18/23 at 3:30 PM, an observation of the 600 Hall medication cart, with Licensed Practical Nurse #2 (LPN), revealed an opened NovoLog FlexPen pre-filled multi-dose insulin pen with no date indicating when the pen was opened. LPN #2 confirmed there was no date on the multi-dose pen or the box the pen was stored in. LPN #2 stated that all insulin pens should have a date written on the pen or box indicating the date it was opened so the insulin could be discarded on the 28th day. LPN #2 explained that the nurse is responsible for dating the insulin when it is opened and that administering insulin after the	F 761	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 12/20/203 the six residents having multi-dose insulin pens that were open and unlabeled were provided new insulin pens, all six being labeled and dated upon opening. The opened, unlabeled pens were discarded. 2.Identification of other residents having the potential to be affected was accomplished by: On 12/22/2023 the Charge Nurse conducted an audit of all residents having a physician order for an insulin pen. The facility has determined that the six diabetic residents identified with prescribed insulin pens have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed Practical Nurse (LPN) #2 and LPN #3 were in-serviced on the labeling of drugs and biologicals by the Director of Nursing on December 22, 2023. All nurses were in-serviced by the Director of Nursing on the labeling of drugs and biologicals on December 27th and December 29, 2023. The incident of the residents was taken to the Quality	

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F 761	Continued From page 19 discard date could cause the insulin to be less effective. On 12/19/23 at 9:39 AM, an observation of the 300 Hall medication cart, with LPN #3, revealed a NovoLog FlexTouch prefilled multi-dose insulin pen with no date indicating when the pen was opened. LPN #3 stated that the pen should be dated so the nurses would know when to discard the insulin. She explained that giving opened insulin past the discard date could make the insulin less effective. Record review of the Manufacturer's literature revealed the Novolog FlexPen and Novolog FlexTouch insulins that are "In-use" could be stored for 28 days and "Instructions for Use" indicated, " ...Do not use NovoLog past the expiration date printed on the label or 28 days after you start using the Pen ..." On 12/20/23 at 3:09 PM, in an interview with the Director of Nursing (DON), she stated that insulin should be dated when it is opened by the nurse to ensure they were discarded timely. The DON explained that if a nurse gave an insulin injection to a resident after the time it should have been discarded, the insulin might not work as well.	F 761	Assurance (QA) Committee on January 5, 2024. 4.How the corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning on December 22, 2023, weekly for a period of twelve weeks, the Staff Development Nurse will audit all medications carts monitoring for the correct labeling of opened insulin pens and she will maintain a log of her findings. Beginning on December 22, 2023 the Medical Records Nurse will audit these logs for twelve weeks. Beginning on December 22, 2023 the findings of this audit will be discussed at the weekly Quality Assurance and Performance Improvement (QAPI) meetings for twelve weeks. Beginning on Jan 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) Meeting for three months. 5.Corrective Action Completion Date Corrective Action completion date January 12, 2024	
F 812 SS=F	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	F 812		1/12/24

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F 812	Continued From page 20 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to store foods safely as evidenced by food left open and exposed on shelves, undated/unlabeled foods without a use-by -date, food stored without an identifying label, and not discarding food items after their "use-by" or "sell-by" date for one (1) of two (2) kitchen observations. Findings Include: A review of the facility's policy titled, "Food and Supply Storage", review date 08/2021, revealed, "All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption ... Most products contain an expiration date. The words "sell-by" or "use-by" should precede the date ... The "sell-by", "best-by" or "use-by" date is the last date that a food can be consumed... Foods past the "use-by", "sell-by", "best-by", or "enjoy-by" date should be discarded ...Cover, label and date unused portions and open packages ..."	F 812	1.Immediate action(s) taken for the resident(s) found to have been affected include: On December 18, 2023, the Dietary Manager made sure that all exposed foods were closed, and all undated, unlabeled foods without a use by date were discarded. All foods stored with an expired use by or sell by date were also discarded. The Dietary Manager inspected and ensured all unused portions and opened packages were covered, labeled, and dated. 2.Identification of other residents having the potential to be affected was accomplished by: On December 22, 2023 the Nursing Hone Administrator conducted an interview with the Dietary Manager to be informed that the kitchen had failed to properly store and label foods. This interview revealed that all residents receiving meals from the kitchen have the potential to be affected.	

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F 812	Continued From page 21 On 12/18/23 at 10:44 AM, an initial tour of the kitchen with the Dietary Manager revealed the following: 1. In refrigerator #1 there was (1) opened, undated container of sliced jalapeno peppers partially covered by plastic wrap, with one corner of the container exposed. There were three (3) one-pound blocks of margarine with no date on the wrapper. The margarine blocks had wrappers that were pulled back, exposing the margarine. There were 45 individual serving bowls of what the dietary manager identified as carrot cake, with no label or use by date noted on the bowls. There was (1) opened plastic bag, with decorating tip of dairy whipped topping, with no dates noted on the bag. There were (2) five-pound unopened plastic bags of shredded cheddar cheese with no date on the package Additionally, there was (1) unopened half gallon of butter milk with a sell by date of 12/06/23 and (1) large unopened plastic package of salad mix, containing lettuce, carrots, and purple cabbage, with a use by date of 11/29/23. 2. An observation of the freezer revealed there was (1) undated, plastic storage bag of cornbread. There were two (2) undated, unopened packages of frozen waffles and (1) opened, undated package of waffles. Additionally, there were six (6) undated,unlabeled and unopened slabs of pork ribs as identified by the Dietary manager and (1) undated, turkey breast. 3. An observation of a shelf in the food preparatory area revealed seven (7) containers of seasonings with the lids opened and the seasonings exposed. There was also (1) bag opened bag of light brown sugar, leaving the	F 812	3. Actions taken/systems put into place to reduce the risk of future occurrence include: On December 22, 2023, the Dietary Manager was in-serviced by the Administrator on the policies of Food Procurement, Store/Prepare/Serve Sanitary. On December 27th and December 29th, 2023, the Dietary Manager in-serviced all Dietary staff on Food Procurement, Store/Prepare/Serve Sanitary. Citation F812 was taken to the Quality Assurance (QA) Committee on January 5, 2024. 4.The following corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning December 22, 2023 weekly, for a period of twelve weeks the Nursing Home Administrator will conduct an unannounced kitchen audit to ensure that Food Procurement, Store/Prepare/Serve Sanitary requirements are being met. The Administrator will maintain a log of her findings. Beginning December 22, 2023 the Director of Support Services will audit these logs weekly for twelve weeks. Beginning Dec 22, 2023 findings of this audit will be discussed at the weekly for twelve weeks at the Quality Assurance and Performance Improvement (QAPI) meetings with the Dietary Manager present. Beginning on January 12, 2024 this plan of correction will be monitored at the quarterly Quality Assurance (QA) meetings for three months. 5.Date of completion of the Corrective	

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F 812	Continued From page 22 sugar exposed. No staff were standing near the seasoning or sugar, indicating that they were being used. On 12/18/23 at 10:44 AM, during an interview with the Dietary Manager (DM), he acknowledged the outdated, unlabeled, opened, and exposed foods. The DM stated it is a mistake but understands the hazard of having outdated foods that a resident could consume. The DM stated these items should have been discarded. The DM revealed it is every kitchen employee's responsibility to watch for expired foods and discard food as it reaches the expiration date. The DM stated the staff that opens a container should put an open date on the package. On 12/19/23 at 10:52 AM, an interview with Kitchen Staff #2/Cook, revealed everyone is responsible for disposing of expired foods. The cook stated all kitchen staff are supposed to look at labels and are responsible for dating an item when it is opened. On 12/19/23 at 10:55 AM, during an interview with Kitchen Staff #3/Prep, revealed all staff are supposed to look at labels and are responsible for disposal of expired foods. Kitchen Staff #3 reported it is the responsibility of the person that opens a food item to date that item. On 12/19/23 at 11:36 AM, during an interview with the Administrator, acknowledged the failure of the facility to discard outdated foods, to label foods properly, and to securely close food containers. The Administrator confirmed the potential hazard of a resident consuming outdated foods. The Administrator stated her expectation is that the kitchen staff will monitor for outdated foods and	F 812	Action Plan The corrective Action completion date is January 12, 2024	

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F 812	Continued From page 23 dispose of these foods immediately, as she expects the kitchen staff to ensure food safety for residents.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		1/12/24

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F 867	Continued From page 24	F 867		

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 25 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867	Continued From page 26 Based on staff interview, record review, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to correct a quality deficiency from a previous survey for one (1) re-cited deficiency of five (5) cited deficiencies from a previous annual recertification survey in October 2021. The deficiency was related to initiating and implementing care plans. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee. Findings Include: Record Review of the facility's policy, "Quality Assurance and Performance Improvement (QAPI) Program" revised August 2017, revealed, " ...The facility shall ...maintain an ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems...Policy Interpretation and Implementation The objectives of the QAPI Plan are to ...5. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome ...Evaluation 1. The facility shall evaluate the effectiveness of its QAPI Program ..." During the current recertification survey, the State Agency (SA) identified deficient practice of F656: Based on observation, interviews, record review, and facility policy review, the facility failed to develop a comprehensive care plan for a resident (Resident #21) who had an indwelling catheter and failed to implement comprehensive care plan interventions for medication administration (Resident #21) and toenail care (Resident #34)	F 867	F867- QAPI/QAA Improvement Activities 1.Immediate action(s) taken for the resident(s) found to have been affected include: On December 22, 2023 the Care Plan Nurse developed and implemented a comprehensive care plan for resident #21 to include care for an indwelling catheter. The Charge Nurse assessed resident #21 on December 18, 2023 finding the pulse and blood pressure within normal limits. Nail care was provided for resident #34 on December 19, 2023. The Director of Nursing and the treatment nurse completed an assessment of each residents nails on December 22, 2023. The Care Plan Nurse updated Resident #34s care plan on December 23, 2023. 2.Identification of other residents having the potential to be affected was accomplished by: On December 22, 2023 the Care Plan Nurse conducted an audit on all residents having a physicians order for an indwelling Catheter. The audit revealed that all residents having an indwelling catheter have the potential of being affected. On Dec 22, 2023 the Director of Nursing and the Treatment Nurse completed a nail audit on all residents dependent on staff for nail care. Finding from this assessment revealed that all residents dependent on staff for nail care have the potential to be affected. . On December 22, 2023 the charge nurse performed an audit identifying all residents with a physician order, requiring a pulse	

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F 867	Continued From page 27 for two (2) of 16 resident care plans reviewed. On 12/20/23 at 03:00 PM, in an interview with the Administrator, she confirmed the previous annual recertification survey conducted in October of 2023 included a citation regarding the development/implementation of the Comprehensive Care Plan. She explained the facility completed all the corrective action per the Plan of Correction (POC) from the survey and the facility continued to conduct monthly in-services related to resident care plans. The Administrator said the facility had a staff member that came to the facility monthly and audited charts and care plans, but this person had not completed the December audit. She stated that the facility conducts a daily morning meeting in which all new physician orders are discussed and determine any new care plans that needed to be initiated. She confirmed she has reviewed the CMS (Centers for Medicare and Medicaid Services)-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction) and the facility completed the correction plan, however, the facility failed to develop and implement care plans for two residents during the current survey. On 12/20/23 at 03:15 PM, during an interview with the Director of Nursing (DON), she explained she was aware of the previous deficiencies from the recertification survey in October 2021 but had a different job title at that time. She confirmed on the previous recertification survey, the facility was cited for failing to develop/implement the comprehensive care plan.	F 867	obtained prior to a medication administration. This audit revealed that all resident requiring a pulse check prior to a medication administration have the potential of being affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence include: On December 22, 2023 the Director of Nursing provided one on one in servicing to the Care Plan Nurse educating him on Comprehensive Care Plans. On 12/27/23 and 12/29/23, all nurses were in-serviced by the Director of Nursing on the importance of following the Comprehensive Care Plan Policy. On December 22, 2023 the incidents of Residents #21 and #34 were taken to the Quality Assurance (QA) Committee. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning December 22, 2023 weekly, for a period of twelve weeks, the Medical Records Nurse will audit a sample of five (5) Care Plans weekly to ensure that Care Plans are consistent with the facility's policy and State and Federal regulations. The Medical Records Nurse will maintain a log of her findings. Beginning on December 22, 2023 the Director of Nursing will audit these logs, weekly, for twelve weeks to ensure care plans are being reviewed. Beginning on December 22, 2023 the findings of this audit will be discussed at the weekly Quality	

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F 867	Continued From page 28	F 867	Assurance and Performance Improvement (QAPI) meetings, for twelve weeks. Beginning on January 12, 2024 This plan of correction will be monitored at the quarterly Quality Assurance (QA) meeting for three months. Beginning on January23, 2024 the Staff Development Nurse will begin monthly in servicing one year to Direct Care Staff on Implementing and Following Comprehensive Care Plans, 5. Correction Action Completion date: The corrective Action completion date is January 12, 2024.	