STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. BUILDING _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE JACKSON, MS 39204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual re-certification and Complaint Investigation (CI) MS #21501, at the facility from 05/15/2023 through 05/18/2023. The SSA investigated CI MS #21501 for food palatability, adequate grooming, and temperature of water and cited no deficiencies related to the complaint. During the survey, the SSA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F578, F623, F656, F740, and F761. The facility had a census of 94 and was licensed for 100 beds.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		6/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/2023

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure that residents who do not have an Advance Directive (AD) received information or assistance in formulating an AD for ten (10) of ten (10) residents reviewed for ADs. This deficient practice had the potential to affect all residents who do not have an AD. Resident #11, Resident #14, Resident #21, Resident #31, Resident #45, Resident #55, Resident #65, Resident #67, Resident #86, and Resident #90. Findings include: A review of the facility's policy "Advance Directives" dated 8/2017, revealed, "...It is the policy of the Facility to respect the resident's right	F 578	1. Starting on May 16, 2023 Social Service provided Resident #11, Resident #14, Resident # 21, Resident # 31, Resident #45, Resident #55, Resident #65, Resident #67, Resident #86, and Resident #90 with information or assistance in formulating an Advanced Directives. Resident #11, Resident #14, Resident # 21, Resident # 31, Resident #45, Resident #55, Resident #65, Resident #67, Resident #86, and Resident #90 still reside in the facility and had no ill effects from this deficient practice. 2. All residents have the potential to be	

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F 578	Continued From page 2 of self-directed care including the right to issue Advance Directives...2. Upon admission the Facility will provide each resident medically deemed competent or resident's representative, who does not have an existing Advance Directive, with written information and instruction regarding the right to make Advance Directives prior to the initiation of care or at any requested time...c. The resident's instructions, the resident's receipt of written information, and the existence or non-existence of the resident's Advance Directive must be documented in the resident's record...Procedure: 1. The Facility/Staff who admits the resident to the Facility will provide the resident or personal representative with an information packet containing: a. Advance Directives Information Sheet b. A copy of literature regarding planning in advance for your medical treatment and appointing a health care agent...2. Each resident or personal representative, will be asked if the resident has any Advance Directive. a. Whether or not an Advance Directive exists shall be documented in the Resident's medical record...c. If Advance Directives do not exist: The staff will refer the resident or personal representative to the information provided in the Advance Directives packet. If the resident or personal representative requests further instruction, he/she will be instructed by staff and referred to community resources such as an attorney, physician..." A record review of the facility's Face Sheets revealed the facility admitted Resident #11 on 10/23/17 with a diagnosis of Dry Eye Syndrome of Unspecified Lacrimal Gland, Resident #14 on 11/8/13 with a diagnosis of Hypertensive Heart Disease, Resident #21 on 12/28/16 with a diagnosis of Hypertensive Heart Disease,	F 578	affected from this deficient practice. 3. An in-service was initiated on May 19, 2023 by the Director of Nursing Service (DNS) for Unit Managers and Social Services Director on ensuring residents who do not have an Advance Directive receive information or assistance in formulating an Advance Directive. Starting on May 16, 2023, a 100% audit on resident Advance Directives was initiated by Social Service and DNS on ensuring residents who do not have an Advance Directive receive information or assistance in formulating an Advance Directive. Any concerns will be immediately addressed by Social Service. 4. The DNS will audit 10 charts per week times eight (8) weeks to ensure that resident who do not have an Advance Directive receive information or assistance in formulating an Advance Directive beginning on May 19, 2023. Any concerns will be immediately addressed by the DNS. The DNS will forward the resident who do not have an Advance Directive audits results to the Quality Assurance Committee monthly times two (2) starting with the Quality Assurance meeting on June 28, 2023. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved.	

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Resident #31 on 4/22/22 with a diagnosis of Hyperlipidemia, Resident #45 on 3/19/20 with a diagnosis of Spondylolysis, Resident #55 on 9/14/22 with a diagnosis of Diabetes Mellitus, Resident #65 on 7/31/20 with a diagnosis of Hypothyroidism, Resident #67 on 3/26/21 with a diagnosis of Nutritional Deficiency, Resident #86 on 7/7/22 with a diagnosis of Encephalopathy, and Resident #90 on 10/19/22 with a diagnosis of Hypothyroidism.

Record review of the medical record for Resident #11, Resident #14, Resident #21, Resident #31, Resident #45, Resident #55, Resident #65, Resident #67, Resident #86, and Resident #90 revealed there was no documentation that the resident or the Resident Representative (RR) received information on formulating an AD.

On 5/16/23 at 1:53 PM, in an interview with the Social Services Director (SSD) and the Admissions Coordinator (AC), the SSD stated that she did not have anything to do with ADs when a resident is admitted to the facility, however, the code status of residents was discussed with the resident or the RR quarterly at care plan meetings. The SSD said that she also sent a resident's rights AD notification annually to the resident or the RR to inform them they have a right to make an AD. The SSD confirmed that she did not include any documentation in her notes or elsewhere pertaining to information given to the resident or the RR regarding assistance in formulating an AD and she did not document the existence or nonexistence of an AD in the resident's record. The AC stated that she asked upon admission if the resident had an AD, and if they did, she ensured that a copy was placed in the medical record. The AC confirmed

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that she did not determine whether the resident wished to formulate an AD, and did not document the existence or the nonexistence of an AD in the resident's record.

On 5/17/23 at 4:45 PM, in an interview with the Executive Director, she stated that she felt as if the staff were following the facility policy related to ADs as far as ensuring that all residents are asked upon admission if they have an AD. She stated that the resident or the RR signed the Admissions Packet which included information related to ADs. She said that it has been her experience that the SSD was responsible for ensuring that the resident's instructions, and receipt of written information, including whether the resident had an AD or not, was documented in the resident record and that the lack of that documentation was the missing piece.

On 5/18/23 at 8:48 AM, in an interview with the SSD, and an observation of the facility's AD packet, "Advance Directives Legal Documents To Assure Future Health Care Choices", the SSD confirmed that she did not provide the AD packet to residents or the RR upon admission, however, she did provide the packet "upon request" by the resident or family.

Record review of the "Resident Rights/Advance Directives" notification form, dated 8/2017, revealed the facility provided residents and RRs with notification concerning the right to make an AD, however, the form did not include information that confirmed the existence or nonexistence of an AD or information on formulating an AD.

A record review of the "Admission Agreement", dated 9/16/2019, revealed, "...Advance

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F 578	Continued From page 5 Instruction or Directives Policy 20.1 The Facility will comply with applicable state law and regulation concerning health care treatment decisions..." The Admission Agreement did not include information that confirmed the existence or nonexistence of an AD or information on formulating an AD.	F 578		
F 623 SS=D	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 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;	F 623		6/28/23

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F 623	Continued From page 6	F 623		

(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 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

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F 623	Continued From page 7 (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 record review, interviews, and facility policy review, the facility failed to ensure a written notification of transfer was sent to the Resident's Responsible Representative, included the reason of transfer for one (1) of two (2) records reviewed. Resident #88. Findings include: A record review of the facility's policy, "Discharge and Transfer Policies - Involuntary" reviewed 1/15, revealed, "Policy: Transfer and discharge	F 623	1. On May 17, 2023 a written transfer notice including the reason for transfer was sent by the Director of Nursing Service (DNS) to Resident #88's Responsible Representative with a reason for transfer. Resident #88 had no ill effects from this deficient practice. 2. All residents who transfer have the potential to be affected by this deficient	

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F 623	Continued From page 8 includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not ... Procedure: ... 6. Before a facility transfers a resident to a hospital ...the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding bed-hold policies..." A record Review of Resident #88's "Discharge/Transfer Notice," dated 05/11/23, revealed the resident was transferred to an acute care hospital. No reason for hospitalization was evident of the form. A record review of Resident #88's "Physician's Telephone Orders," with order date 5/11/2023, revealed, " ... May transfer to acute care hospital due to blood noted from around penile area and hematuria." A record review of Resident #88's "Face Sheet" revealed the facility admitted the resident on 03/13/23, with diagnoses that included Personal History of Malignant Neoplasm of Prostate and Type 2 Diabetes. On 5/17/23 at 02:00 PM, during an interview with the Business Manager, she reported the Director of Nurses (DON) is responsible for filling in the Discharge/Transfer Notice and she is only responsible for mailing it. On 05/17/23 at 02:10 PM, during an interview with the DON, she explained she is the staff member responsible for filling out the Discharge/Transfer Notice. The DON looked at the Discharge/Transfer Notice for Resident #88	F 623	practice. 3. An in-service was initiated on May 19, 2023 by the Clinical Operations Nurse for the DNS and Unit Managers on written transfer notice including the reason for transfer is sent to the Resident's Responsible Representative. 4. Starting on May 19, 2023 the DNS will audit 10 resident transfer charts per week times eight (8) weeks to ensure that written notification including reason of transfer was sent to the Resident's Responsible Representative. Any concerns will be immediately addressed by the DNS. The DNS will forward the written notification including reason of transfer to the Resident's Responsible Representative audits results to the Quality Assurance Committee monthly times two (2) starting with the Quality Assurance meeting on June 28, 2023. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved.	

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F 623	Continued From page 9 and confirmed that the reason for the transfer of the resident to the acute care hospital was not noted on the form.	F 623		
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	F 656		6/28/23

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F 656	Continued From page 10 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 observations, interviews, record review, and facility policy review, the facility failed to implement a care plan to include providing the necessary behavioral health services per physician orders for one (1) of two (2) residents reviewed for behaviors. Resident #90 Findings include: A record review of the facility's policy "Comprehensive Person-Centered Care Plans" dated 3/18, revealed, " ... Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care ..." A record review of Resident #90's Comprehensive Care Plan, revealed a problem onset of 03/31/23, stating the resident " ...has the potential for alteration in mood as evidenced by verbal aggression ..." and approaches listed included " ... Psychological assessment as needed ..."	F 656	1. Resident #90 obtained a psychological assessment for any necessary behavioral health services on May 17, 2023, by a geriatric psychiatric practitioner. Resident #90 care plan was implemented including any necessary behavioral health services per physician orders on May 19, 2023 by Social Services. Resident #90 had no ill effects from this deficient practice. 2. All residents who require any necessary behavior health services per physician orders have the potential to be affected by this deficient practice. 3. An in-service was initiated on May 19, 2023 by the Director of Nursing Service (DNS) for Unit Managers and Social Services on ensuring residents care plan who require any necessary behavior health services per physician orders. Starting on May 18, 2023, a 100% audit	

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F 656	Continued From page 11 Record review of Resident #90's "Physician's Telephone Orders" dated 03/16/23, revealed " ...may transfer resident to Geri Psych hospital for evaluation ..." Another "Physician's Telephone Order" dated 04/07/23, revealed an order to "refer to in-house behavioral health services for assessment of executive deficit and agitation." On 05/15/23 at 12:10 PM, Resident #90 was observed in his doorway talking to a staff member very loudly about the red things in his corn. He kept repeating numerous times, "I don't know what they are, so I am not eating it." The resident continued to stand in the doorway of his room and continued to talk/cry loudly to anyone coming down the hall regarding the corn. On 05/15/23 at 12:35 PM, Resident #90 was observed sitting in a chair in his room. The resident continued to loudly complain about the corn. While discussing his recent hospitalization, Resident #90 explained they sent me to the hospital because I said I was leaving on the 1st of the month and they wanted to see if I was for real, but I wasn't. Resident appeared very anxious regarding the hospital visit and the corn. On 05/17/23 at 03:00 PM, during an interview with Registered Nurse (RN)/Unit Manager, she explained Resident #90 went to a behavioral health unit a couple of months ago, as the resident had been become very loud, was exit seeking, and had been cursing. Upon return from the behavioral health unit, the resident had been started on new medication and had been doing better. The Unit Manager revealed she is not sure if the resident gets behavioral services after returning from the behavioral health unit.	F 656	on resident with behaviors was initiated by the Unit Managers and Social Service on ensuring a care plan to include providing the necessary behavioral health services per physician orders. 4. The DNS will audit 10 charts per week times eight (8) weeks to ensure that resident care plan who require necessary behavior health services per physician orders. Any concerns will be immediately addressed by the DNS. The DNS will forward the resident care plan who require necessary behavior health services audits results to the Quality Assurance Committee monthly times two (2) starting with the Quality Assurance meeting on June 28, 2023.	

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	255125	A. BUILDING _____ B. WING _____	05/18/2023

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F 656	Continued From page 12 On 05/17/23 at 03:34 PM, during an interview with Director of Nurses (DON), she explained Resident #90 was sent to a Geri-psych hospital on 03/18/23 and had returned to the facility on 03/29/23. The DON revealed she did not know orders had been written by the Nurse Practitioner on 04/07/23, for the resident to be evaluated for in house behavioral health services and had been care planned for those services. The DON confirmed that Resident #90 had not been receiving behavioral health services per physician orders and his care plan. On 05/18/23 at 10:45 AM, during an interview with Licensed Practical Nurse (LPN) #4, she explained she completes the care plans for residents. The purpose of the care plan is to identify how the staff will provide care for the resident and she expects care plans to be followed. Record review of Resident #90's "Face Sheet" revealed the facility admitted the resident on 10/19/20, with the diagnoses of Hypothyroidism, Encephalopathy, Dementia. Record review of Resident #90's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/23, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Section E indicated Resident #90 displayed psychotic behavior, that did not include hallucinations and delusions.	F 656		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services.	F 740		6/28/23

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F 740	Continued From page 13 Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide the necessary behavioral health services per physician orders for one (1) of two (2) residents reviewed for behaviors. Resident #90 Findings include: On 05/15/23 at 12:10 PM, an observation of Resident #90 revealed he was standing in his doorway talking very loudly to a staff member about the red things in his corn. He kept repeating numerous times, "I don't know what they are, so I am not eating it." Resident #90 was observed getting louder as he continued to stand in his doorway talking about his corn to anyone he saw coming down the hall. On 05/15/23 at 12:35 PM, Resident #90 was observed sitting in a chair in his room, continuing to loudly complain about the corn. The resident appeared very anxious while talking about his corn and his recent hospitalization. Resident #90 explained the facility sent me to the hospital because I said I was leaving on the 1st of the month and they wanted to see if I was for real, but I wasn't.	F 740	1. Resident #90 obtained a psychological assessment for any necessary behavioral health services on May 17, 2023, by a geriatric psychiatric practitioner. Resident #90 had no ill effects from this deficient practice. 2. All Residents with physician orders to provide the necessary behavior health services have the potential to be affected by this deficient practice. 3. Starting on May 18, 2023, a 100% audit to provide the necessary behavioral health services per physician orders was initiated by the Unit Managers and Social Service. An in-service was initiated on May 17, 2023 by the Director of Nursing Service (DNS) for the Unit Managers and Social Services regarding following physician orders for residents to provide the necessary behavioral health services. 4.	

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F 740	Continued From page 14 On 05/17/23 at 02:15 PM, during an interview with Certified Nurse Assistant (CNA) #1, she explained that once Resident #90 says something or does something inappropriate, he is not always easily redirected. On 05/17/23 at 02:35 PM, during an interview with CNA #2, she explained Resident #90 acts out at times with cursing and yelling at staff and is very impatient. On 05/17/23 at 03:00 PM, during an interview with Registered Nurse (RN)/Unit Manager, she explained a couple of months ago, Resident #90 was exit seeking and became very verbal with loud cursing. At that time, the facility referred Resident #90 to a behavioral health unit, and he had been admitted. While in the behavioral health unit, the resident was prescribed a new medication and upon return to the facility he had been doing much better. Record review of Resident #90's "Physician's Telephone Orders" dated 03/16/23, revealed " ...may transfer resident to Geri Psych hospital for evaluation ..." Record review of a "Physician's Telephone Order" dated 04/07/23, revealed an order to "refer to in-house behavioral health services for assessment of executive deficit and agitation." On 05/17/23 at 03:34 PM, during an interview with the Director of Nurses (DON), she explained Resident #90 had started talking about going home and had begun exit seeking. Resident #90 refused to wear a wander guard, so the resident was placed on visual checks, however, on	F 740	Starting on May 17, 2023 the DNS will audit 10 charts per week times eight (8) weeks to ensure resident physician orders for necessary behavioral health services. Any concerns will be immediately addressed by the DNS. The DNS will forward the resident care plan who require necessary behavior health services audits results to the Quality Assurance Committee monthly times two (2) starting with the Quality Assurance meeting on June 28, 2023.	

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F 740	Continued From page 15 03/02/23, it became necessary to place the resident on one-on-one supervision, as the exit seeking behavior began to increase. On 03/16/23, Resident #90 packed his bags and headed towards the doors to leave. An order was received to transfer the resident to a Geri-psych hospital for evaluation on 03/16/23, and the daughter gave permission for the transfer on 03/18/23. Upon return to the facility, the DON revealed the resident had been doing better. The DON confirmed Resident #90 had not had any behavioral health services since his return from the Geri-psych unit and admitted that she was unaware of the orders written by the Nurse Practitioner for Resident #90 to be referred to in-house behavioral health services for assessment. The DON confirmed Resident #90 has not been receiving behavioral health services. Record review of the "Face Sheet" for Resident #90, revealed the facility admitted resident on 10/19/20, with the diagnoses that included Hypothyroidism, Encephalopathy, and Dementia. Record review of Resident #90's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/23, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Section E indicated Resident #90 displayed psychotic behavior, that did not include hallucinations and delusions.	F 740		
F 761 SS=E	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	F 761		6/28/23

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F 761	Continued From page 16 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 observations, interviews, record review, and facility policy review, the facility failed to date an opened insulin vial and failed to a remove an expired insulin pen and insulin vial from medication carts for two (2) of three (3) medication carts reviewed. Findings include: A record review of the facility's policy, "Expiration Dating and Document Requirements," with a revision date of 01/2015, revealed, " ... Medications will be discarded by the product expiration date OR the date on which the	F 761	1. Resident #86 an Unsampled Resident was assessed by the Director of Nursing Service (DNS) on 05/18/23 and had no ill effects from this deficient practice. Resident #86 and an Unsampled Resident undated opened insulin vial and expired insulin pen and insulin vial were removed from the medication carts and reordered by the Director of Nursing Service on May 17, 2023. 100% medication carts were audited on 05/18/23 by the Unit Managers to ensure that there was no opened insulin vials,	

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F 761	Continued From page 17 suggested length of time after opening the product has passed, whichever occurs first..." A record review of the facility's policy, "Insulin Pens," with a revision date of 08/2016, revealed, " ... Check the date the insulin pen was opened and discard per manufacturers' guidelines. Date and initial new insulin pens upon opening ..." On 05/17/23 at 4:20 PM, an observation of the A hall medication cart with Licensed Practical Nurse (LPN) #2, revealed a vial of Humulin R 100 unit/ml Insulin in a box without an open date on the box or vial. On 05/17/23 at 4:25 PM, in an interview with LPN #2 she revealed she should have checked the cart at the beginning of her shift, and discarded the undated insulin, as insulin should be labeled upon opening the vial and discarded after 28 days. She explained that she had no way of knowing when the insulin was opened, and expired insulin is not effective and should not be used. On 05/17/23 at 4:30 PM, in an interview with LPN #1/ Unit Manager, she confirmed that nurses should date the insulin when its opened, as insulin cannot be used after being open for more than 28 days. On 05/17/23 at 4:35 PM, in an observation of the split cart located on the A hall with LPN #1/Unit manager, a Lantus Solostar 100 unit/ml insulin prefilled pen was observed without an open date for an unsampled resident. The observation also revealed there was a Lantus 100 unit/ml insulin vial, labeled for Resident #86, with an opened date of 3/31/23.	F 761	expired insulin vials and expired insulin pens. 2. All Residents who use insulin pens and insulin vials have the potential to be affected by this deficient practice. 3. An in-service was initiated on dating open insulin vial and removal of expired insulin pen and insulin vial from medication carts on May 17, 2023 by the Director of Nursing Service (DNS) for Licensed Practical Nurses and Registered Nurses. 4. Starting on May 19, 2023 the DNS or Unit Manager will audit four (4) medication carts two (2) times a week times eight (8) to ensure that open insulin vials are dated and removal of expired insulin pen and insulin vial from medication carts audits. Any concerns will be immediately addressed by the DNS. The DNS will forward that open insulin vials are dated and the removal of expired insulin pen and insulin vial from medication carts audits results to the Quality Assurance Committee monthly times two (2) starting with the Quality Assurance meeting on June 28, 2023.	

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F 761	Continued From page 18 On 05/17/23 at 4:50 PM, in an interview with LPN #1/ Unit Manager, she revealed that insulin given after 28 days of opening is not effective. She confirmed the insulin pen without an open date should be discarded and the Lantus 100 unit/ml vial, belonging to Resident #86 should have been disposed of on 4/27/23. On 05/18/23 at 9:58 AM, in an interview with the Director of Nurses (DON), she confirmed that once insulin is opened, you have 28 days to use it. She stated her expectation is that nurses who open medication should date it and that the medication should be discarded according to the product expiration date or the manufacturers' guidelines, which for insulin is 28 days.	F 761		