DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Jeanne Jugan Residence

DATE SURVEY COMPLETED: October 27, 2022

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint was conducted at this facility from October 18, 2022, to October 27, 2022. During this period an Emergency Preparedness Survey was also conducted by the State of Delaware's Division of Health Care Quality Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 31. The survey sample totaled		
3201	23 residents. Regulations for Skilled and Intermediate Care		
3201.1.0	Facilities		
3201.1.2	Scope Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 27, 2022: F623, F684,		

Provider's Signature Sr Cecile Beringue Title administrator Date 11/15/22

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	F695, F732, F755, F761, F812.		

Provider's Signature Sr. Cécile Zeringue Title Administrator Date 11/15/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08A006	A. BUILDING _____ B. WING _____	C 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from 10/18/2022 and ending 10/27/2022 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 31. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility beginning 10/18/2022 and ending 10/27/2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was thirty-one (31) residents. The investigative sample totaled twelve (12). Abbreviations/definitions used in this report are as follows: ADON- Assistant Director of Nursing; BP- Blood Pressure; BIMS (Brief Interview for Mental Status)- a tool to assess mental status; CCHS (Christiana Care Health System)- a Hospital; CNA- Certified Nurse Aide; DON- Director of Nursing; DX- Diagnosis;	F 000		

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

Electronically Signed | 11/15/2022

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 000	Continued From page 1 ER- Emergency Room; EMR- Electronic Medical Record; Exacerbation- Increase of symptoms; Flow Meter- An instrument used to assess the flow of oxygen; HR- Human Resources; Humidifier Bottle- Water attached to a oxygen concentrator to humidify the air delivered by Oxygen; Hypoxia- Low level of Oxygen; Lethargic- Lack of energy; Liter- Unit of measurement; LPN- Licensed Practical Nurse; Nasal Cannula- Tube to deliver Oxygen through the nose; NHA- Nursing Home Administrator; Ombudsman- A person who promotes nursing home resident rights and quallty of care; 02- Oxygen; Oxygen Concentrator- a device that concentrates Oxygen from the air; Pulse Ox- Instrument that measures the Oxygen content of blood; RA- Room Air; RN- Registered Nurse; SW- Social Worker; Via- Through; Void- Empty the bladder; W/C- Wheelchair.	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	F 623		12/27/22

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F 623	Continued From page 2 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; (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;	F 623		

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F 623	Continued From page 3 (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 (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	F 623		

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F 623	Continued From page 4 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 and clinical record reviews, it was determined that for three out of four sampled residents (R1, R5 and R30) reviewed for hospitalization/discharge, the facility failed to provide notice of the hospital transfers to the Ombudsman. Findings included: 1. R5's clinical record revealed: 4/26/22 to 4/29/22 - R5 was hospitalized. 10/27/22 at 9:06 AM - During an interview, E5 (SW) confirmed that the Ombudsman's Office was not notified of R5's April 2022 hospitalization. 2. R30's clinical record revealed: R30 was admitted to the facility in 2018. 5/29/22 to 6/10/22 - R30 was hospitalized. 10/25/22 at approximately 3:00 PM - E2 (DON) was interviewed and asked if the Ombudsman was notified of R30's transfer to the hospital. E2 stated, "I don't know." 10/25/22 at approximately 3:10 PM - E5 (Social Services) was interviewed and confirmed that she	F 623	A) During the survey ending on 10/27/22, the Surveyor upon reviewing the medical records found Residents R1, R5, and R30 did not have written notification of hospital transfer to the State Ombudsman Office. B) Though R1, R5, and R30 were not negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The Social worker or designee will conduct a focused review of all resident transfers/discharges in the past 30 days to identify any other incidents when the ombudsman office was not notified. If any are identified, notification will be completed. C) Root cause analysis revealed that the facility had not sent notification to the Ombudsman office. Review of the Hospital Transfer checklist Policy revealed Ombudsman Notification was not a part of the process and therefore does require revision. Social Services contacted the Ombudsman office and discussed the appropriate plan for submissions of notifications for hospital transfer (See	

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F 623	Continued From page 5 didn't know that the Ombudsman was supposed to be notified when residents were transferred to the hospital or discharged. 3. Review of R1's clinical record revealed: 8/22/14- R1 was admitted to the facility. 8/18/22 to 8/23/22 - R1 was hospitalized. 8/24/22 to 8/29/22 - R1 was hospitalized. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 10/27/22, beginning at 3:15 PM.	F 623	attached Hospital Transfer checklist and Transfer log). D) The Social Worker will audit all transfers to the hospital to ensure ombudsman notification occurred each time. The audit will be completed weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted monthly x3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and review of the facility policy, it was determined that the facility failed to ensure that medications were administered in accordance with the resident care plan and per Physician orders for two (R1 and R30) out of 12 sampled residents. Findings include: Review of the facility policy entitled Medication,	F 684	A) During the survey ending on 10/27/22, the Surveyor upon reviewing the medical records found Resident R30 did not receive their ordered Nexium for nine days and R1 did not receive their ordered Exemestane for three days due to awaiting pharmacy delivery. B) The facility recognizes all Residents	12/27/22

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F 684	Continued From page 6 Administration, last reviewed August 2018, stated, "...20. If medication is ordered but not present: a. Reasonable time for new medications is twenty-four (24) hours if ordered after 4 p.m. or arrival in the Pharmacy Tote during the third (3rd) shift... b. If any discrepancies, phone the pharmacy to inform of not receiving the medication. The nurse must notify their supervisor...". Cross refer to F755 1. R30's clinical record revealed: R30 was admitted to the facility in 2018. 4/12/22 - Review of R30's care plan included a potential nutritional problem related to GERD (gastroesophageal reflux disease or acid reflux), including medication as ordered. 6/11/22 - A physician's order was written for Nexium DR (delayed release) 40 mg by mouth every morning for GERD. Review of the electronic Medication Administration Record (eMAR) for August 2022 revealed that Nexium was not administered from 8/15 through 8/23, nine days, despite a Physician's order for it to be given daily. Review of the progress notes from 8/15/22 through 8/23/22 revealed that "awaiting (pharmacy) delivery" followed by the initials of the assigned nurse was present daily for Nexium. The progress notes lacked evidence that the pharmacy was called, the Nursing Supervisor was notified and/or that the Physician was advised so they had an opportunity to give a new	F 684	have the potential to be affected by this deficient practice. The Consultant Pharmacist reviews the Resident's charts and medications monthly, but did not pickup on the awaiting deliveries. ADON and DON reviewed last 30 days of all Resident's charts for "awaiting delivery". Other Residents were identified has having this issue. While medical staff reviewed Resident's charts, it was discovered that the medications were noted to be awaiting delivery in the order eMAR note (between the facility and pharmacy). C) Root cause analysis revealed that the facilities method for documenting awaiting delivery in an order eMAR note limited certain facility staff from seeing the need for delivery of medications. Moving forward, if a medication is "awaiting delivery" the nurse must document in a health status note (not eMAR note), that the medication is awaiting delivery, that the pharmacy was notified, and if the medication is not delivered within the 24 hour period, per facility policy, the physician must be notified, as well as their supervisor. The DON or her designee will audit Resident's charts for medications that are awaiting delivery and the appropriate documentation (See attached Review of Resident's charts/Awaiting Delivery). D) The Consultant Pharmacist will continue to audit the charts monthly. The DON or her designee will audit Resident's charts for medications that are awaiting	

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F 684	Continued From page 7 order or state what they wanted to do until the medication was available. 8/25/22 - The above Physician's order was revised and stated "stock." The 8/15/22 - 8/23/22 progress notes lacked evidence that Nexium was obtained from stock medications (meds) and/or administered. 10/25/22 at approximately 3:00 PM- E2 (DON) was interviewed. Concerns about the lack of Nexium administration were reviewed and confirmed. When asked what her expectation was, E2 stated the Nurses were to call the Physician to get the medication order changed or advise that they can't get the medication, an example was given for the medication being on back order. Before that, E2 stated that the Nurse should have already called the pharmacy to find out when the medication would be delivered so the Nurse had the information to give to the Physician. The Surveyor asked if there was a document to show if Nexium was signed out for administration from facility stock meds. None was received by the survey exit on 10/27/22. 2. Review of R1's clinical record revealed: 10/22/14- R1 was admitted to the facility. 9/5/22- A physician's order was written for Exemestane Tablet 25 mg by mouth daily for breast cancer. 10/17/22 through 10/19/22- Progress note: Exemestane Tablet 25 mg. Give 25 mg by mouth in the morning for breast cancer for 90 days after meal awaiting delivery.	F 684	delivery and the appropriate documentation, 2 times a week until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be done monthly for 3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	

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F 684	Continued From page 8 The 10/1/22-10/27/22 electronic medication administration record revealed that Exemestane Tablet 25 mg was not documented as administered to R1 on 10/17/22, 10/18/22 and 10/19/22. 10/27/22- 2:45 PM- During an interview, E2 (DON) confirmed that Exemestane was not administered to R1 on 10/17/22, 10/18/22 and 10/19/22. Findings were reviewed with E1 (NHA) and E2 during the Exit Conference on 10/27/22, beginning at 3:15 PM.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observations and interview, it was determined that for one (R29) out of 12 sampled residents, the facility failed to ensure that R29 received respiratory care consistent with her physician orders. Findings include: Review of the facility's policy: Oxygen Therapy, Nasal Cannula revised 8/2018, revealed the following:	F 695	A) R29's Oxygen concentrator was changed and humidifier bottle was replaced on 10/25/22. B) All Residents have the potential to be affected by O2 concentrators without humidifier bottles. All Resident receiving O2 have been reviewed, humidifier bottle orders have been verified, and documentation is completed in the	12/27/22

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F 695	Continued From page 9 " ... Policy Purpose: To improve oxygenation and provide comfort to residents experiencing respiratory difficulties. Policy Procedure:... 6. Attach pre-filled humidifier bottle to flow meter if using concentrator... 7. Attach nasal cannula/face mask tubing to humidifier bottle, if using concentrator ...". Review of R29's clinical record revealed: 8/27/18- R29 was admitted to the facility with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). 7/18/22- A physician order was written for Oxygen therapy to be administered to R29 via nasal tubing (nasal cannula) related to COPD with an acute exacerbation (increase of symptoms). 7/19/22- A physician order was written to change the Oxygen tubing and the humidifier every two weeks. 10/19/22- 11:15 AM- R29 was observed to be receiving Oxygen through a nasal cannula attached to an Oxygen concentrator; a humidifier bottle was not attached to the concentrator. 10/24/22- 10:00 AM- R29 was observed to be receiving Oxygen through a nasal cannula attached to an Oxygen concentrator; a humidifier bottle was not attached to the concentrator. 10/25/22- 9:45 AM- R29 was observed to be receiving Oxygen through a nasal cannula attached to an Oxygen concentrator; a humidifier bottle was not attached to the concentrator.	F 695	E-e-MAR. C) Through root cause analysis it was determined that R29's physician order for O2 tubing and humidifier bottle changes were written in the same order in the E-mar. Moving forward the orders will be listed separately in the E-Mar, with 7-3 shift checking and verifying humidifier bottle and equipment to decrease the potential for oversight. Nurses have been informed of the change. The Nursing Supervisor will review that all O2 concentrators have humidifier bottles attached and that a separate order for the O2 humidifier bottle is in the E-Mar (See attached Review of Oxygen). D) The Nursing Supervisor will review that all O2 concentrators have humidifier bottles attached and that a separate order for the O2 humidifier bottle is in the E-Mar. The aforementioned will be conducted weekly for one month and if 100% compliance is obtained, it will be done bi-monthly. After 2 months of bi-weekly checks are complete and 100% compliance has been obtained, it will be done monthly. If at the end of 6 months 100% compliance has been obtained we will determine the practice has been corrected and a final report will be sent to QAPI.	

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F 695	Continued From page 10 10/25/22- 9:50 AM- During an interview, E6 (LPN) confirmed that R29's Oxygen concentrator did not have a humidifier bottle attached. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 10/27/22, beginning at 3:15 PM.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		12/27/22

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JEANNE JUGAN RESIDENCE	185 SALEM CHURCH ROAD NEWARK, DE 19713

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F 732	Continued From page 11 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to post the required nurse staffing information requirement in a prominent place, readily accessible to residents and visitors for two out of two nursing units. Findings include: 1st Floor Observation 10/27/22 8:50 AM - An observation on the 1st floor Holy Family nursing station, revealed that nursing staffing data was posted on the magnetic white board. The posting lacked the licensed nurses and CNA (Certified Nurse Aide) hours and the resident census of the day. 2nd Floor Observation 10/27/22 8:55 AM - An observation on the 2nd floor St. (saint) Joseph nursing station revealed that nursing staffing data was posted on the magnetic white board. The posting lacked the licensed nurses and CNA hours and the resident census of the day. Lobby Hallway Observation 10/27/22 9:00 AM - An observation in the corner of the lobby hallway revealed that nursing staffing data was posted on a legal sized paper and the Surveyor could not easily read from a two foot distance. The posting lacked the facility name. In	F 732	A) During the survey ending on 10/27/22, the Surveyor upon reviewing the posting of required nurse staffing information found that the facility did not post the information in a highly visible location that was easily accessible to Residents and visitors. The postings located on the units did not have the nursing hours (including CNA hours) or Resident census of the day. While the posting in the lobby location listed all the nursing and CNA hours and Resident census, it did not have the facility name listed. On 10/27/22 the required nurse staffing information was updated and immediately posted. The location of the posting was moved from the corner in the lobby to the bulletin board in the lobby and on the nursing units. B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. C) Root cause analysis revealed that the facility did not post the required nurse staffing information in a highly visible area. The HR Director, nursing staff	

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F 732	Continued From page 12 addition, the staffing information was posted in the lobby's corner hallway which was not a prominent place and it was not readily accessible to residents and visitors on the 1st and 2nd floors. 10/27/22 at 12:30 AM - Findings were discussed with E12 (Coordinator) and E13 (HR). Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 10/27/22, beginning at 3:15 PM.	F 732	scheduler, or her designee, will update the census daily and ensure it is posted at the bulletin boards on each nursing unit (near the nurses station) and the bulletin board in the lobby. D) The Assistant Administrator, or their designee, will audit daily to ensure the posting of required nurse staffing information is completed and posted at the designated locations (see attached Review of staffing Postings). The audit will be completed daily until 100% compliance is achieved for 4 consecutive weeks. Then the audit will be conducted weekly for 3 months until 100% compliance is achieved for 3 consecutive months. Then the audit will be conducted monthly for 3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		12/27/22

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F 755	Continued From page 13 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide routine pharmaceutical services for acquiring and receiving medication to meet one residents (R30) needs out 12 sampled. The facility failed to make any attempts to call or contact the pharmacy when R30 ran out of Nexium. As a result, R30 did not receive her Nexium for 9 days from 8/15/22 through 8/23/22. It was unclear whether Nexium was a stock med in the facility at the time and whether it was available to be given in the interim. Findings include: R30's clinical record revealed: Review of the facility policy entitled Medication, Administration, last reviewed August 2018,	F 755	A) During the survey ending on 10/27/22, the Surveyor upon reviewing the medical records found Resident R30 did not receive their ordered Nexium for nine days due to awaiting pharmacy delivery. B) The facility recognizes all Residents have the potential to be affected by this deficient practice. The Consultant Pharmacist reviews the Resident's charts and medications monthly, but did not pickup on the awaiting deliveries. ADON and DON reviewed last 30 days of all Resident's charts for "awaiting delivery". Other Residents were identified has having this issue. While medical staff reviewed Resident's charts, it was	

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F 755	Continued From page 14 stated, "... 20. If medication is ordered but not present: a. Reasonable time for new medications is twenty-four (24) hours if ordered after 4 p.m. or arrival in the Pharmacy Tote during the third (3rd) shift... b. If any discrepancies, phone the pharmacy to inform of not receiving the medication...". Cross refer to F684, example 1 1. R30's clinical record revealed: 6/11/22 - A physician's order was written for Nexium DR (delayed release) 40 mg by mouth every morning for GERD (gastroesophageal reflux disease or acid reflux). Review of the electronic Medication Administration Record (eMAR) for August 2022 revealed that Nexium was not administered from 8/15 through 8/23, nine days, despite a Physician's order for it to be given daily. Review of the progress notes from 8/15/22 through 8/23/22 revealed that "awaiting (pharmacy) delivery" followed by the initials of the assigned nurse was present daily for Nexium. The progress notes lacked evidence that the pharmacy was called. 8/25/22 - The above Physician's order was revised and stated "stock." The 8/15/22 to 8/23/22 progress notes lacked evidence that Nexium was obtained from stock medications (meds) and/or that it was administered. 10/25/22 at approximately 3:00 PM - E2 (DON) was interviewed. Concerns about the lack of Nexium administration were reviewed and when	F 755	discovered that the medications were noted to be awaiting delivery in the order eMAR note (between the facility and pharmacy). C) Root cause analysis revealed that the facilities method for documenting awaiting delivery in an order eMAR note limited certain facility staff from seeing the need for delivery of medications. Moving forward, if a medication is "awaiting delivery" the nurse must document in a health status note (not eMAR note), that the medication is awaiting delivery, that the pharmacy was notified, and if the medication is not delivered within the 24 hour period, per facility policy, the physician must be notified, as well as their supervisor. For OTC medication, if a Resident needs to utilize our house stock, even temporarily, the supervisor will be notified and medication retrieved from medical. The DON or her designee will audit Resident's charts for medications that are awaiting delivery and the appropriate documentation (See attached Review of Resident's Chart/Awaiting Delivery). D) The Consultant Pharmacist will continue to audit the charts monthly. The DON or her designee will audit Resident's charts for medications that are awaiting delivery and the appropriate documentation, 2 times a week until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit	

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F 755	Continued From page 15 asked what her expectation was, E2 stated the Nurse should have called the pharmacy to find out when the medication would be delivered. The Surveyor asked if there was documentation to show if Nexium was signed out for administration from the facility stock meds. None was received by the survey exit on 10/27/22, however, the Surveyor received a list of meds in facility stock entitled OTC (over the counter) Medications that included Nexium 20 mg. It was unclear how many Nexium capsules were in stock as daily administration would require two 20 mg capsules and if Nexium was removed from stock for R30. E2 confirmed this and stated, "We need to come up with a procedure." 10/27/22 at 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2.	F 755	will be done monthly for 3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	
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	F 761		12/27/22

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F 761	Continued From page 16 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Manufacturers' recommendations as indicated, it was determined that the facility failed to ensure that a prescribed drug and biological currently in use must be labeled with the open/discard date to ensure that they are used and disposed of according to the Manufacturers' recommendations. Findings included: Tubersol is a diagnostic biological used to detect Tuberculosis (a potentially serious infectious disease that mainly affects the lungs). According to the Tubersol Manufacturer's package insert (undated), a vial of Tubersol that was opened for 30 days should be discarded. Azelastine is a prescribed medication used to treat allergic rhinitis (stuffy nose/congestion). The Azelastine's Manufacturer's package insert (revised 9/2018) stated, "The correct amount of medication in each spray cannot be assured... after 200 sprays have been used, even though the bottle is not completely empty. The bottle should be discarded after 200 sprays have been used...". 10/26/22 at 10:45 AM - Observation of Medication Storage with E11 (RN) revealed the following: - an opened multi-use vial of Tubersol with no	F 761	A) During the survey ending on 10/27/22, the Surveyor upon auditing a medication cart and refrigerator found that there was an opened multi-use vial of Tubersol with no open date listed and an opened prescribed nasal spray, Azelastine for R28 with no open/discard date listed. B) Though no Residents were negatively impacted, the facility recognizes all Residents have the potential to be affected by this deficient practice. The Consultant Pharmacist will continue to audit the medication carts and refrigerators monthly. In addition, the nurses do audit medication carts and refrigerators monthly at this time. C) Root cause analysis revealed that the facility failed to write the open date on the boxes of these two medications. Moving forward, during audits for expirations by the unit nurses on the 11-7 shift, they will also be checking to ensure that the medications are initialed with an open date (see attached Review of Medications date opened). D) The Consultant Pharmacist will	

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F 761	Continued From page 17 open date listed; and - an opened prescribed nasal spray medication, Azelastine, for R28 with no open/discard date listed. Findings were immediately confirmed with E11 during the observation and interview. 10/27/22 at 3:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 761	continue to audit the medication carts and refrigerators monthly. The unit nurse on the 11-7 shift will check to ensure that medications have an open date and initials 2 times a week until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be conducted weekly until 100% compliance is achieved for 3 consecutive weeks. Then the audit will be done monthly for 3 months, if 100% compliance is achieved/maintained, this deficiency will be considered resolved. Results of audits will be presented at the facility's QAPI meetings. Audit schedules will be adjusted as deemed necessary.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		12/27/22

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F 812	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility did not store food and utensils in a sanitary manner. Findings include: The following were observed on 10/18/22 from 1:10 PM to 2:10 PM during the initial kitchen tour: 1. The ceiling tile in the fume hood area was loose. 2. The dry storage area had uncovered fluorescent light bulbs. Findings were reviewed and confirmed with E19 (Food Service Director) on 10/18/22 at approximately 2:00 PM. 10/27/22 at 3:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 812	A) The ceiling tiles in the fume hood area were immediately replaced on 10/18/22. The lights in the dry storage area will be replaced with new LED fixtures. B) Although no staff or Residents were affected by the loose ceiling tile or uncovered light bulbs, all Residents and staff have the potential to be affected by the loose ceiling tile or uncovered light bulbs. C) It will be the responsibility of the maintenance staff to install the new lights in the dry storage area. They will be installed by 12/1/2022. The maintenance director will inspect the new lights after installation. The maintenance staff will do monthly checks on ceiling tiles in the kitchen area. D) The maintenance director will inspect the new lights after installation. The maintenance staff will do monthly checks on ceiling tiles in the kitchen area. After 3 months of 100% compliance, this deficiency will be considered resolved. All findings will be reported to the QAPI team.	