STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	**1303 HEALTH DRIVE NEW BERN, NC 28560**

(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 COVID-19 Focused Survey was conducted on 2/3/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# CC1811.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 02/03/2021 The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 2 of the 7 complaint allegation(s) were substantiated resulting in deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		3/1/21

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

Electronically Signed | 02/19/2021

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and legal Guardian and staff interviews the facility failed to notify the legal Guardian of a change in condition in the resident and failed to notify the physician that a prescribed medication was unavailable for 1 of 2 residents	F 580	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or	

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F 580	Continued From page 2 (Resident #1) reviewed for notification of change. Findings included: 1. Resident #1 was readmitted to the facility on 12/21/2020 with diagnoses of anxiety disorder, and feeding difficulties. Resident #1's record revealed the resident had a legal guardian with the necessary paperwork on record. The significant change Minimum Data Set (MDS) dated 1/13/2021 indicated Resident #1 was cognitively severely impaired. Resident #1 required extensive assistance with eating and had impairments of the upper and lower extremities on both sides. The MDS specified Resident #1 had no symptoms of a swallowing disorder and had a significant weight loss. The MDS revealed Resident #1 was on hospice care. A Physician Communication form dated 12/2/2020 written by Nurse #1 revealed Resident #1 had signs of a decline with a decrease in appetite and had started to gag on a pureed diet. A telephone interview with Nurse #1 on 2/8/2021 at 1:44 pm revealed she did not normally work with Resident #1. Nurse #1 stated she completed the physician communication form on 12/2/2020 which stated Resident #1's had a decrease in appetite and was gagging on the pureed diet. Nurse #1 stated she did not call Resident #1's legal Guardian to report the changes in swallowing or decrease in appetite. Nurse #1 revealed she worked with Resident #1 on 12/2/2020 and did not think to call the family to report the changes.	F 580	that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. Resident #1 no longer resides at the facility. An audit of current residents was completed looking back fourteen days to ensure that nursing staff appropriately notified legal guardians of any change in condition. This will be completed by February 24, 2021 by the Director of Health Services/designee. Any missed opportunities will be completed at time of discovery. An audit of current resident medication administration records was completed looking back fourteen days to ensure that nursing staff appropriately notified the physician of any prescribed medication not being available. This will be completed by February 26, 2021 by the Director of Health Services/designee. Any missed opportunities will be completed at time of discovery. Licensed Nurses were re-educated on February 22, 2021 by the Registered Nurse Clinical Competency Coordinator on providing notification to legal guardians when a change in condition occurs and notification to the physician when a prescribed medication is not available. The Director of Health Services/Designee will review nursing progress notes for	

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F 580	Continued From page 3 A Physician Communication form dated 12/27/2020 completed by Nurse #2 specified Resident #1 was not eating, or drinking, and was refusing medications. The form stated Resident #1 scratched the nurse aide when she attempted to assist with the meal. An interview with Nurse #2 on 2/7/2021 at 1:00 pm revealed she had completed the Physician Communication note dated 12/27/2020 which stated Resident #1 was not eating food, drinking fluids, or taking medications. Nurse #2 stated she did not call Resident #1's legal Guardian because she communicated the changes to the hospice nurse. Nurse #2 stated the assigned nurse was supposed to call the resident's Representatives or Guardian to report changes in conditions. A progress noted dated 12/31/2020 written by Nurse #3 revealed a Hospice Nurse came to the facility to evaluate and admit Resident #1 to hospice services. The interview with Resident #1's legal Guardian on 2/3/2020 at 4:00 pm revealed she was unaware that Resident #1 was not eating, drinking, or not taking medications. Resident #1's Guardian stated she did not know Resident #1 was in such a poor condition until the Administrator called on 12/31/2020 and spoke with her about hospice services for Resident #1. An interview conducted with the Administrator on 2/9/2021 at 11:32 am revealed there was not a specific staff member designated to contact a resident's Guardian about a change in condition. The Administrator stated each department was responsible for reporting changes in a Resident's	F 580	changes in condition to ensure that the legal guardian was notified. This will occur five times a week for four weeks then monthly times one. The Director of Health Services/Designee will review medication administration records for prescribed medications listed as unavailable to ensure that the physician was notified. This will occur five times a week for four weeks then monthly times one Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Compliance Date March 1, 2021	

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F 580	Continued From page 4	F 580		

condition to the Representative or Guardian. The administrator stated the Nurse should have contacted the Resident #1's Guardian to report the changes.

2. Review of Resident #1's care plan dated 9/4/2020 indicated Resident #1 received an anxiolytic (drug to reduce anxiety) medication. The interventions included to administer medications as ordered, to observe for signs and symptoms of adverse side effects and to notify the physician as needed.

A physician order dated 1/11/2021 for Resident #1 revealed an order for lorazepam intensol 0.2 milliliters every 6 hours for anxiety.

Review of Resident #1's Medication Administration Record (MAR) for the month of January 2021 indicated the lorazepam intensol was unavailable from 1/11/2021 through 1/14/2021. The MAR revealed Nurse #5 contacted the Nurse Practitioner on 1/13/2021 for a handwritten prescription for the lorazepam.

An interview on 2/4/2021 at 2:00 pm with Nurse #5 revealed Resident #1 moved to her hall on 1/12/2021 and did not have the lorazepam intensol available in the medication cart or in back up medications. Nurse #5 stated on 1/12/2021 she did not know the medication was on hold for a hand-written prescription. Nurse #5 stated she thought the medication would be delivered later during the day on 1/12/2021. Nurse #5 stated after speaking with the pharmacy on 1/13/2021 about why Resident #1's medication had not been delivered, she informed the Nurse Practitioner that a handwritten prescription was needed to obtain the medication.

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F 580	Continued From page 5 An interview with the Administrator on 2/9/2021 at 11:32 am revealed Nurse #5 should have contacted the physician to let him know the medication was not available to see if he wanted to change the medication.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		3/1/21

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F 585	Continued From page 6	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 7 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on the Guardian, staff interviews, and record reviews, the facility failed to issue a written decision regarding actions taken by the facility to resolve a grievance for 1 of 2 resident (Resident #1) reviewed for grievances. Findings included: Resident #1 was readmitted to the facility on 12/21/2020 with the diagnoses of anxiety disorder and feeding difficulties. The Significant Change Minimum Data Set (MDS) dated 1/13/2021 indicated Resident #1 was severely cognitively impaired.	F 585	Resident # 1 no longer resides at the facility. An audit of facility grievances for the last 60 days was completed to ensure that the facility issued a written decision regarding the actions taken by the facility to resolve the grievance. This was completed by the Nursing Home Administrator on February 19, 2021. Nursing Home Administrator 1 & 2 were re-educated by the Area Vice President on February 22, 2021 on F585 Grievances 483.10(j)(4)(v).	

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F 585	Continued From page 8 A grievance form dated 5/15/2020 revealed Resident #1's hearing aid was lost at the facility. The grievance was written and investigated by Administrator #1. The grievance form revealed Administrator #1 was the Grievance officer. The grievance summary revealed Resident #1's room was searched for the hearing aid. The grievance form indicated all department managers were informed of the missing hearing aid. The grievance form revealed the Director of Human Services (DHS) purchased amplifiers for Resident #1 to resolve the concern. The form indicated the purchase of the amplifier was verbally shared with Resident #1 and Resident #1's Guardian. Administrator #1 signed that Resident #1's Guardian had been informed of the results. The grievance form had no indication that a written summary had been sent to Resident #1's Guardian. A telephone interview on 2/3/2021 at 3:00 pm with Resident #1's Guardian revealed she found out about Resident #1's hearing amplifiers from a nurse when she called to check on Resident #1. The Guardian stated she did not receive a written summary or decision from the facility concerning the lost hearing aid. The Guardian stated she would have welcomed a written response to Resident #1's grievance so that she would know the facility investigated the lost hearing aid. The guardian stated she was okay with the amplifiers while Administrator #1 obtained the $400.00 deductible to replace Resident #1's lost hearing aid. An interview with the Social Worker (SW) on 2/3/2021 at 1:00 pm revealed grievances were handled by the Administrator. The SW stated the Administrator was responsible for sending out a	F 585	The Social Worker/Designee will audit resolved/closed grievances to ensure that the facility issued a written decision regarding the actions taken by the facility to resolve the grievance. This will occur weekly for four weeks then monthly times one. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance March 1, 2021	

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F 585	Continued From page 9 written grievance summary. A telephone interview with Administrator #2 on 2/9/2021 at 11:32 am revealed grievances should be resolved as soon as possible. Administrator #2 stated Resident #1's Guardian should have received a grievance written summary. Administrator #2 stated she was not at the facility during the time of the grievance and she could not determine if a grievance summary had been sent to Resident #1's Guardian. An Interview with Administrator #1 on 2/12/2021 at 4:00 pm revealed he did not send a resolution letter to Resident #1's Guardian. Administrator #1 stated he put in a request for the $400 deductible to replace the lost hearing aid . Administrator #1 stated he was then transferred to another facility.	F 585		
F 641 SS=E	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 record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for immunizations for 3 (Residents #3, #4, & #5) of 5 residents reviewed for immunizations. The findings included: 1. Resident #3 was admitted to the facility on 11/30/2018. Her diagnoses included chronic pain syndrome, quadriplegia, and neuromuscular bladder dysfunction.	F 641	Resident number 3, 4 & 5 had their Minimum Data Set modified to accurately code for immunizations on February 22, 2021. An immunization audit from October 1, 2020 through February 2021 was completed to ensure that the Minimum Data Set was accurately coded for immunizations. Any discrepancies noted will be corrected at time of discovery. This will be completed by February 26, 2021 by	3/1/21

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F 641	Continued From page 10 A review of the Influenza Vaccine for Patient/Resident Consent/Refusal Form revealed it was signed on 10/5/2020 by Resident #5. The form also documented Resident #3 received an influenza vaccination on 11/3/20 at 3:00 PM in the left deltoid. A review of the Preventive Health Care report revealed Resident #3 received the influenza vaccine of N1H1 on 11/3/20. A review of the quarterly Minimum Data Set (MDS) dated 11/23/20 revealed Resident #3 was cognitively intact. Section O, Influenza vaccination was coded no. The MDS indicated the influenza vaccination was not offered. On 2/8/21 at 3:15 PM MDS nurse #1 stated the computer documentation indicated the influenza shot was given but because there was not lot number or expiration date listed on the Preventative Health Care documentation form, she coded the MDS as the immunization was not given. She stated there were no other records for the resident because all the information was uploaded into the electronic health record. The MDS nurse stated she would need to do a corrected MDS to indicate the resident did receive the vaccination. On 2/8/21 at 3:45 PM the Administrator stated the immunization consent forms were in binders in the infection control nurse ' s office because the previous infection control nurse was the nurse who gave the influenza shots. The Administrator stated the resident did receive the immunization so the MDS was incorrect.	F 641	the Director of Health Services/Designee. The Minimum Data Set Nurses will be re-educated by February 26, 2021 on properly coding the Minimum Data Set for immunizations. The Director of Health Services/Designee will audit immunizations given to residents to ensure that the Minimum Data Set was accurately coded. This will occur weekly for four weeks then monthly times one. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance March 1, 2021	

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F 641	Continued From page 11	F 641		

2. Resident #4 was admitted to the facility on 10/18/19. Her diagnoses included major depression, hypertension, and mood disorder.

A review of the Influenza Vaccine for Patient/Resident Consent/Refusal Form revealed it was signed on 10/21/20 by Resident #5. The form also documented Resident #5 received an influenza vaccination on 10/21/20 at 10:00 AM in the LD (left deltoid).

A review of the Preventative Health Care record in Resident #4s electronic health record revealed she received the influenza vaccine of H1N1 on 10/21/20

A review of the annual Minimum Data Set (MDS) dated 11/2/20 revealed Resident #4 was cognitively intact. Section 0 revealed influenza vaccination was not assessed/no information.

On 2/8/21 at 3:15 PM MDS nurse #1 stated the computer documentation indicated the influenza shot was given but because there was not lot number or expiration date listed on the Preventative Health Care documentation form, she coded the MDS as the immunization was not given. She stated there were no other records for the resident because all the information was uploaded into the electronic health record. The MDS nurse stated she would need to do a corrected MDS to indicate the resident did receive the vaccination.

On 2/8/21 at 3:45 PM the Administrator stated the immunization consent forms were in binders in the infection control nurse ' s office because the previous infection control nurse was the nurse who gave the influenza shots. The Administrator

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stated the resident did receive the immunization so the MDS was incorrect.

3. Resident #5 was admitted to the facility on 5/29/20. Her diagnoses included congestive heart failure and respiratory failure.

A review of the Influenza Vaccine for Patient/Resident Consent/Refusal Form revealed it was signed on 11/3/20 by Resident #5. The form also documented Resident #5 received an influenza vaccination on 11/3/20 at 3:00 PM in the left deltoid.

A review of the Preventative Health Care record in Resident #5s electronic health record revealed she received the influenza vaccine of H1N1 on 11/3/20.

A review of the quarterly Minimum Data Set (MDS) dated 1/13/21 revealed Resident #5 was cognitively intact. Section O, Influenza Vaccination was answered no. The MDS indicated the influenza vaccination was not offered.

On 2/8/21 at 3:15 PM MDS nurse #1 stated the computer documentation indicated the influenza shot was given but because there was not lot number or expiration date listed on the Preventative Health Care documentation form, she coded the MDS as the immunization was not given. She stated there were no other records for the resident because all the information was uploaded into the electronic health record. The MDS nurse stated she would need to do a corrected MDS to indicate the resident did receive the vaccination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 641	Continued From page 13 On 2/8/21 at 3:45 PM the Administrator stated the immunization consent forms were in binders in the infection control nurse's office because the previous infection control nurse was the nurse who gave the influenza shots. The Administrator stated the resident did receive the immunization so the MDS was incorrect.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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)-	F 656		3/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 14 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a care plan in the area of pressure ulcers for 1 of 2 residents (Resident #1) reviewed for care plans. Finds included: Resident #1 was readmitted to the facility on 12/21/2020 with the diagnoses of anxiety disorder and feeding difficulties. Review of Nurse #1's progress note dated 12/21/2020 indicated Resident #1 was readmitted to the facility with a deep tissue pressure injury to the left lateral heel and unstageable pressure injury to the sacrum. The significant change Minimum Data Set (MDS) assessment dated 12/28/2020 indicated Resident #1 was severely cognitive impaired. Resident #1 required extensive assistance with eating and had impairments of the upper and lower extremities on both sides. The MDS revealed Resident #1 had a stage one pressure ulcer, one unstageable pressure ulcer, and five deep tissue	F 656	Resident #1 no longer resides at the facility. An audit of all current residents with pressure ulcers will be completed by February 26, 2021 to ensure that the facility had developed a care plan for pressure ulcers. This will be completed by the Director of Health Services/designee. Any missed opportunities will be completed at time of discovery. Licensed Nurses were re-educated by February 22, 2021 by the Registered Nurse Clinical Competency Coordinator on properly developing care plans relating to pressure ulcers. The Director of Health Services/Designee will review new identified residents with pressure ulcers to ensure that a care plan was developed. This will occur five times a week for four weeks then monthly times one.	

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F 656	Continued From page 15 injuries. A review of Resident #1's care plans revealed no care plan for Resident #1's pressure ulcers. An interview with the MDS Director on 2/3/2021 at 10:30 am revealed a care plan for Resident #1's pressure ulcers should have been added to the care plans upon Resident #1's readmission to the facility. The MDS Director stated after the Significant Change MDS assessment was completed, the care plan for Resident #1's pressure ulcers should have been developed. A telephone interview with the Administrator on 2/9/2021 at 11:32 am revealed with any significant changes in a resident's condition, the care plan should be updated.	F 656	Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of Compliance March 1, 2021	