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	345144	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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E 000	Initial Comments An unannounced recertification and complaint survey were conducted on 006/14/2021 through 06/17/2021. The facility was found in complaince with requirement CFR 483.73, Emergency Preparedness. Event ID # 88D011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 06/14/2021 through 06/17/2021. Event ID #88D011. One of the three complaint allegations was substantiated resulting in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		7/31/21

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

Electronically Signed | 07/12/2021

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to treat a resident in a respectful and dignified manner for one of one resident reviewed for dignity, when the Speech Therapist (ST) and a Nursing Assistant referred to a resident as a feeder (Resident #3). Findings included: Resident #3 was admitted to the facility on 8/16/19. The resident's diagnoses included: Heart failure, anxiety, renal failure, diabetes, chronic obstructive pulmonary disease, chronic respiratory failure, and dementia. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 6/3/21 indicated Resident #3 had moderately impaired cognition. The resident was	F 550	Pine Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pine Ridge Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 550	Continued From page 2 coded as having required extensive assistance of one to two people for bed mobility, dressing, toilet use, personal hygiene, and the resident supervision with one-person physical assist for eating. Further review revealed the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months and was receiving hospice care. Review of Resident #3's care plan revealed a focus area for Activities of Daily Living (ADL)/Personal Care which had an intervention of Eating: Provide total feeding. Feed resident slowly, puree diet, and honey thickened liquids. Further review revealed the resident was receiving Hospice Care due to a terminal illness and was receiving hospice services from the local hospice agency. An observation was conducted on 6/14/21 at 1:03 PM while the lunch meals were being passed to residents in their rooms. The ST asked Resident #3 if he was a "feeder," to which the resident did not respond due to cognitive impairment. The ST then proceeded to go out in the hall and call out to a Nursing Assistant (NA) in the hall asking if Resident #3 was a "feeder." During an interview conducted on 6/16/21 at 9:16 AM with NA #1 she stated Resident #3 did not eat by himself and he was a "feeder." An interview was conducted on 6/17/21 at 8:56 AM with the ST. She stated Resident #3 fed himself and typically he was not a "feeder." She said if a resident required assistance with feeding, then the resident is a "feeder." She stated she was aware of not calling residents a "feeder" due to concern over respect for the	F 550	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F550 Resident Rights/Exercise of Rights Resident #1 was affected by the deficient practice. Resident #1 is not oriented to place or person and will not be referred to as feeder. Resident #1 will be referred to by their preferred name. All residents have the potential to be affected by the alleged deficient practice. Residents who need assistance with dining will not be referred to as feeders. Residents will be referred to by their preferred name. On 07/05/2021 the administrator completed a resident rights - dignity and respect audit. Beginning 07/05/2021 the administrator, director of nursing (DON), staff development coordinator (SDC), social worker began in-servicing 100% staff on resident□s rights related to dignity and respect to include addressing residents by their name or how they wish to be addressed. Residents will not be referred to as feeders but will be referred to as residents who need assistance with dining. The in-service will be completed by 07/12/2021.No staff person will be allowed to work until the in-service is completed.	

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F 550	Continued From page 3 resident's dignity. She further explained she would hear residents needed assistance with feeding and residents would not be called "feeders." An interview was conducted with the Director of Nursing on 6/17/21 at 12:43 PM. She stated staff members at the facility should not use the word "feeder" when referring to a resident. She said the appropriate way to refer to a resident would be to say to assist the resident with dining or eating. The Administrator stated during an interview conducted on 6/17/21 at 1:20 PM it was important to respect residents' dignity and privacy. She further stated she would have preferred the ST had conferred with another staff member in a quiet manner, in private, regarding Resident #3's ADL status. She said it was inappropriate to refer to any resident as a feeder.	F 550	The in-service is added to the new staff orientation for all new facility and agency staff. The administrator, DON, SDC, assigned hall nurse, and/or social worker will conduct five dignity rounds each week for three months to ensure residents are treated with dignity and respect. The results of the dignity rounds audits will be reported by Social worker/DON to the daily Interdisciplinary Team (IDT) and the monthly Quality Assurance Performance Improvement (QAPI) Committee for three months to ensure continued substantial compliance and/or make plan revisions.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		7/31/21

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F 553	Continued From page 4 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to invite two of two residents reviewed for care plan meeting invitations (Resident # 27 and Resident # 57). Findings included: 1.Resident #27 was admitted to the facility 12/14/2016 with diagnoses that included cognitive communication deficit, vascular dementia and depression. A review of a quarterly Minimum Data Set (MDS) dated 04/13/2021 revealed that Resident # 27 had no cognitive impairment and was able to make daily care decisions. Further review of Resident # 27's medical record revealed there was no documentation that	F 553	F553 □ Right to Participate in Planning Care On 7/6/21 Resident #27 had a care plan meeting with the interdisciplinary team (IDT). On 7/8/21 Resident #57 had a care plan meeting with the IDT team. All residents have the potential to be affected by the alleged deficient practice. On 7/5/21 the facility completed an audit for all residents in the past 90 days to ensure all residents/resident representatives have been invited to attend care conference. There was no documentation of care plan meetings in the resident medical records. On 7/5/21 social worker obtained the	

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F 553	Continued From page 5 Resident # 27 had been invited to a care plan meeting. On 06/14/2021 at 11:40 AM an interview was conducted with Resident # 27. Resident # 27 revealed that she had never been to a care plan meeting and that she rarely got out of bed so that may be why she had never been asked to attend any meeting related to her care. 2.Resident # 57 was admitted to the facility on 12/14/2016 with diagnoses that included lack of coordination, anemia and lymphedema. A review of a quarterly MDS dated 05/03/2021 revealed that Resident # 57 had no cognitive impairment and was able to make daily care decisions. An interview with Reside # 57 conducted on 06/15/2021 at 9:19 AM revealed that Resident # 57 had never been invited to a care plan meeting. Resident # 57 stated, "What on Earth is that? I have no idea what you are talking about." When the care plan meeting was explained to Resident # 57, she revealed that she had not been invited to a care plan meeting. Further review of Resident # 57's medical record revealed there was no documentation that Resident # 57 had been invited to a care plan meeting. On 06/16/2021 at 11:00 AM an interview was conducted with the facility social worker (SW) and the assistant SW (ASW). The ASW revealed that he had been employed at the facility for a little over a month and that he had not personally attended a care plan meeting for Resident # 27 or	F 553	MDS care plan meeting calendar and prepared a calendar for July 2021 to capture all upcoming care plans meeting dates. Residents will be notified of upcoming care plan meetings and asked their preference for inviting a resident representative. If a resident representative is requested by resident, the social worker will mail out a Care Plan Invitation Letter to the resident representative at least 72 hours prior to the care plan meeting. During the care plan meeting, there is a care plan meeting sign-in sheet for meeting attendees to sign. Copies of the care plans are given to the resident/resident representative if requested. Once the care plan meeting is complete, documentation of the care plan meeting will be put into the resident□s electronic health record. On 7/5/21 the Administrator in-serviced the IDT/Clinical members on resident□s right to be invited to care plan meetings. The facility will audit 5 care plans/week x1 month, 3 care plans/week x 1 month and 1 care plan/week x1 month to ensure the resident/resident representative are invited to participate, the care plan is appropriately documented in the electronic health record, and the care plan meeting calendar is being followed. The Quality Assurance Performance	

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F 553	Continued From page 6 Resident # 57. The ASW revealed that he had not attended any care plan meetings for long term care residents. The SW revealed that she had been employed for about 2 weeks and had not been given the direction to begin to invite residents or family members of residents to care plan meetings as of this date. The SW explained that she understood that the role of care plan meeting invitations would eventually be a duty that the SW department would be responsible for and that she would definitely invite all residents to their care plan meetings quarterly and as needed. On 06/16/2021 at 11:21 AM an interview was conducted with the Business Office Manager (BOM). The BOM revealed that she had tried to schedule care plan meetings for residents and families while the SW department was new and settling into their roles. The BOM revealed that it was usually a task of the SW department to arrange care plan meetings for the residents. The BOM reviewed the medical records for Resident # 27 and Resident # 57 and confirmed that there was no care plan meeting documentation for either resident and that she could not confirm if either resident had ever been invited to or attended a care plan meeting. The temporary MDS nurse was interviewed on 06/17/2021 at 9:10AM. The MDS nurse explained that she was not involved in resident care plan meetings in any way and that she did not know the status of care plan meeting invitations or any of the care plan meeting participants. The MDS nurse believed that a nurse unit manager may have been included in any actual care plan meetings. The nurse unit manager (UM) was interviewed on	F 553	Improvement (QAPI) Committee will review the results of the audits for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring and make recommendation for monitoring for continued compliance	

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F 553	Continued From page 7 06/17/2021 at 11:07 AM. The UM reported that she had previously attended care plan meetings and that all residents that were alert and oriented were invited by the previous SW to attend their care plan meetings but the UM also revealed that she was not able to confirm if either Resident # 27 or Resident # 57 had attended a care plan meeting. The facility administrator was interviewed on 06/17/2021 at 4:02 PM. The administrator stated that she expected all residents to be invited to their care plan meetings and invitations, attendance and progress notes be maintained in each resident's medical records.	F 553		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	F 563		7/31/21

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F 563	Continued From page 8 (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, family member interview, and staff interviews, the facility had imposed a regimented schedule which determined not only a limited amount of visits, but also a limited amount of time a resident ' s family was a allowed to visit a resident receiving hospice services for one of one resident reviewed for visitation (Resident #3). This practice had the potential to impact other residents as evidenced by there having been nine total residents on a Compassion Care Visit List, including Resident #3. Findings included: Resident #3 was originally admitted to the facility on 8/16/19 and was most recently readmitted on 3/4/21. The resident was residing in a semi-private room at the time of the recertification. Review of a document titled "Guidelines on Visitation for Nursing Homes (May 2021 Update) revealed in section 3-Compassionate Care Visitation: Using a patient-centered approach, facility leadership should always allow visitation for compassionate care situations, including: End of life situations. As an attachment to the	F 563	F 563 Right to Receive/Deny Visitors Resident #3□s family was notified of current visitation status and requirements for Compassionate Care/End of Life visits. All residents have the potential to be affected by the alleged deficient practice. On 7/09/2021 the Administrator completed an audit on all residents on Compassionate/End of Life Care visitation list and the social worker notified residents and families of current visitation status and requirements for Compassionate Care/End of Life visits. For residents placed on compassionate/end of life care in the future: 1)the social worker(s), activities director, admissions director, receptionist, hall nurses, and/or administrator will notify residents and families of visit changes by telephone and letters, 2) care plans will reflect compassionate/end of life care visits. On 07/05/2021the administrator in-serviced the Interdisciplinary Team	

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F 563	Continued From page 9 guidelines there was a sheet titled, "Guidance to Screener." The guidance included: No family member or friend may visit patient without a pre-arranged visitation time, a patient may not receive more than two (2) visitors a time; children must be supervised at all times, and visits may not exceed half an hour at this time (flexibility may be required under patient-centered care). A letter dated May 2021, with Dear Resident, Family Member, Local Ombudsman and Trusted Employee as the salutation, detailed information regarding the facility ' s visitation. The letter documented the facility reserves the right to limit the number of visitors to two (2) per resident and to schedule the visitations at a time when staff can be available to supervise and assist with the process. Additionally, the letter documented the reader was to be advised that they must call to schedule visitations in advance and that the current visiting hours were: Monday through Friday from 10:00 AM to 12:00 PM and 2:00 PM to 4:00 PM and Saturday and Sunday from 10:00 AM to 12:00 PM and 2:00 PM to 4:00 PM. An undated document from the facility, titled Compassion Care Visit List had nine residents listed. Each resident had two assigned days, with assigned times. Resident #3 was listed as having a scheduled visit time on Wednesday at 3:00 PM and Sunday at 4:00 PM. The Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD) of 6/3/21 indicated Resident #3 had moderately impaired cognition. Further review revealed the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months and was receiving hospice	F 563	(IDT) and residents on current visitation status and requirements. The facility social worker, admissions director, and/or administrator will monitor weekly the CMS, regional DHHS, local Ombudsman, and/or the county health department to ensure the facility is following the most resent visitation guidelines. The weekly updates will be discussed by the administrator and/or social worker in daily interdisciplinary team (IDT) meetings so all departments are updated on visitation/resident rights to receive or deny visitors until COVID related restrictions are lifted. Facility will complete 5 audits/week x1 month, 3 audits/week x 1 month and 1 audit/week x1 month to ensure resident/POA/staff are aware of visitation status and requirements. Results of the audits will be reported to QAPI committee and reviewed for trends and need for additional monitoring to ensure continued regulatory compliance.	

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F 563	Continued From page 10	F 563		

care.

Review of Resident #3's care plan revealed a focus area which documented the resident was receiving Hospice Care due to a terminal illness and was receiving hospice services from the local hospice agency. The listed interventions included: Provide the resident with support during stages of dying: grieving, powerlessness, denial, anger, and acceptance; and provide supportive, private environment for resident and family.

A phone interview was conducted on 6/15/21 at 3:52 PM with a family member of Resident #69. The family member stated she was only allowed to visit the resident twice per week, on Wednesday and on Sunday. She said it made it difficult because there were several family members who had wanted to visit with the resident, but the visitation was only allowed twice per week, and only two family members were allowed to visit the resident at a time. She further stated the resident was receiving hospice services for end of life care and she was worried about the resident ' s declining condition. She said she felt like the resident was aware of the limited visitation because he would ask how come they did not come and visit him as often as they used to visit.

An interview was conducted with the Social Services Assistant (SSA) conducted on 6/16/21 at 9:20 AM. The SSA stated when families call regarding visitation, he forwarded the call to the front desk. The SSA said there was a schedule up front regarding when family members could visit residents. He explained the visits were limited to 30 minutes and only the resident was only allowed to have 2 visitors.

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The receptionist stated during an interview conducted on 6/16/21 at 9:37 AM that she was involved with the process of scheduling visits for residents. She stated routine visits for visitors and residents took place outside and if they wanted privacy, the conference room was available. She stated there were 6 time slots each day and they could only accommodate 2 families and 2 residents at a time. Regarding compassionate care visits for residents, the residents who were eligible for compassionate care visits followed their date and time of visits from the Compassion Care Visit List. The receptionist explained Resident #69 was on the compassion care list and his scheduled visitation times were Wednesday at 3:00 PM and Sunday at 4:00 PM. She said the visits were limited to two visitors at a time and the visits used to be limited to 30 minutes, but due to the change in the guidelines the visits can last about an hour. She said the family members of the residents were made aware of the information regarding visitation through a letter which was sent out, or if the family member were to call she would explain the process for visiting residents at the facility.

During an interview with Nurse #1 conducted on 6/16/21 at 2:25 PM she stated compassionate care visits were set up through schedule with scheduled visits for family. She explained family members could not come visit residents each day, they could visit twice a week on their assigned days. She further stated the visits were limited to two visitors.

An interview was conducted with the Director of Nursing on 6/17/21 at 12:43 PM. She stated the restrictions regarding visitation had changed a lot,

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F 563	Continued From page 12 as in the restrictions had become less restrictive. She said there had been limitations on how often or how long compassionate care residents could have visitors, but those restrictions no longer applied. She stated the family members of Resident #69 should have been able to visit more than twice per week and stay as long as they would like. The Administrator stated during an interview conducted on 6/17/21 at 1:20 PM visitation had recently changed, and family members may visit as many times per week as they would like. She said the visitations used to be limited to 30 minutes, but that restriction no longer applied. She stated a letter had gone out to families a couple of weeks ago explaining the changes in visitation and that families could visit any time they wanted to.	F 563		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		7/31/21

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F 565	Continued From page 13 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to resolve and communicate the facility's efforts to address resident repeated concerns voiced during 4 of 4 Resident Council Meetings. Findings included: The Resident Council Meeting Minutes from October 28, 2020 to March 31, 2021 were reviewed. The review revealed the following concerns were voiced during the monthly Resident Council meetings and the facility's response: Review of the Resident Council Meeting Minutes from October 28, 2020 reported concerns related to:	F 565	F 565 Resident/Family Group and Response By 07/12/2021 the social worker, activities director, and administrator ensured all Resident Council concerns from October 28, 2020, December 28, 2020, January 28, 2021, and March 31, 2021, were addressed, and investigated. All residents have the potential to be affected by the alleged deficient practice. A Resident Council Meeting was conducted on June 16, 2021 and all concerns were recorded, investigated, resolved or ongoing. Results will be reported back as Old Business at Resident Council Meeting in July.	

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F 565	Continued From page 14 A. Residents reported meat is overcooked and burnt. B. Food is unidentifiable and foods are often mixed on plates. C. Some residents do not have menus hanging in their rooms. D. Microwave in dining room does not work. E. Meal trays stay on the hall too long and meals are cold by the time the residents get to eat. F. Maintence request take too long to complete tasks. G. Residents want to know when group activities will resume. There was no documented response the concerns were acted upon by the facility. Review of the Resident Council Meeting Minutes for December 28, 2020 reported concerns related to: A. Food is served cold. B. Condiments not being served with food. C. Family Indoor visitation D. Limited interactions with other residents and no hallway activities due to increased numbers of COVID-19 cases in the community E. Nursing Assistants go out the front doors and are gone for a long time and will just sit in the hall. F. Not enough staff. There was no documented response the concerns were acted upon by the facility. Review of the Resident Council Meeting Minutes for January 28, 2021 reported concerns related to:	F 565	On 07/05/2021 the administrator in-serviced the Interdisciplinary Team (IDT), including Activity Director and activity program assistants, on reviewing the Resident Council meeting minutes Old Business to include Resident Concern resolution. On 07/06/2021 the social worker and/or activities director audited the June 16, 2021, and June 25, 2021, with Ombudsman present to ensure Resident Council□ concerns/grievances were resolved prior to the upcoming July 2021 Resident Council meeting. The audit determined there were 5 unresolved Resident Council concerns. All Resident Council concerns will be resolved prior to the July 2021 meeting and the corrective actions reported to Council during the July 2021 meeting. On 07/26/21 the facility began reviewing the grievance/investigation with the resident, complainant, and/or resident group. The review purpose is to ensure the grievance is accurately documented and expectations are understood. The resident, complainant, and/or resident group will receive a investigation/response letter upon request to sign and keep. If the resolution is not satisfactory or effective, the facility and/or grievant will initiate a follow-up grievance for prompt resolution. Within one week of the Resident Council meeting, the Activities Director, Social Worker and/or Administrator will audit the	

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F 565	Continued From page 15 A. Weekend meals are not as good as meals during the week. B. Meat is hard to identify C. Resident expressed concerns of third shift nursing staff. There was no documented response the concerns were acted upon by the facility. Review of the Resident Council Meeting Minutes for March 31, 2021 reported concerns related to: A. Food served is sometimes different from items listed on the daily menu. B. Family In room visitation. C. Unable to go on outdoor trips or outings in the community due to Covid-19 D. Garbage not being emptied regularly in rooms. E. Not enough staff. F. Medication is sometimes given out late on weekends. There was no documented response the concerns were acted upon by the facility. During a resident council meeting on 6/16/21 at 11:00 AM when the resident council participants were asked question #6 "Does the grievance official respond to the resident or family group response" one resident stated yes I believe they do, however this was his first resident council meeting he had attended. The resident council president was unable to be interviewed. An interview was completed with the Activities Director (AD) on 6/16/21 at 11:39 AM who had been employed with the facility four weeks. The	F 565	Resident Council Minutes. The audit will be for the purpose of 1) identifying any ongoing and/or new Resident Council concerns, 2) communicate the facility's effort to address resident repeated concerns, and 3) satisfactory resolution. The audit will be completed for three months. The audit results will be discussed by the interdisciplinary team (IDT) for identification of trends and recommendations. This IDT review will be completed within 10 days of the Resident Council meeting. The Quality Assurance Performance Improvement (QAPI) Committee will review Resident Council Minutes for three months to identify root causes, trend, and determine if additional monitoring is necessary of continued regulatory compliance.	

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F 565	Continued From page 16 AD stated I know how they were doing it before I started, and this is not how it should have been done. The previous AD did not follow up with the concerns from the previous resident council meetings. The AD stated at the morning meetings a review of concerns was completed and a follow up should have been brought back to the resident council on how the concern was handled. An interview was completed with the Activities Assistant (AA) on 6/16/21 at 12:10 PM who had been with the facility one year. The AA stated that she only led the resident council meetings when there was no AD. AA stated that when residents brought up concerns, we would write up a grievance form and give to the Administrator and then the AA stated she would give the grievance concern form to the correct department. An interview was completed on 6/16/21 at 1:53 PM with the Administrator who stated all of the resident council concerns went to the SW. The Administrator stated she was not receiving all of the concerns or was told by the SW there was not any concerns. The Administrator stated when she would review the resident council minutes that had been given to her it was not consistent as to how responses were handled. The Social Worker (SW) would receive the resident council concerns and it was not being followed the way it should have been and that is why we have a grievance performance improvement project being completed. She stated her expectation was the SW would have followed up on any concerns that were brought up during the meetings.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		7/31/21

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§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.
(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

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F 578	Continued From page 18 appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and maintain advanced directives throughout the medical record for 2 of 2 residents, Resident #77 and Resident #32, reviewed for advanced directives. Findings included: 1. Resident #77 was admitted to the facility on 6/15/2017 with diagnoses of neurological disorder and chronic kidney disease. Resident #77's Physician's Orders did not include an order for advanced directives. A recent Quarterly Minimum Data Set Assessment dated 5/18/2021 revealed Resident #77 was cognitively intact. A review of Resident #77's Care Plan indicated there were no advanced directives included on the care plan. During an interview with Nurse #1 on 6/16/2021 at 5:22 pm she stated the Social Worker usually gets the documentation for the advanced directives and the order for the advanced directives and places the copies on the regular medical record and scans them into the electronic medical record. Nurse #1 stated she could not find the order or copies of the advanced directives on either the regular medical record or the electronic medical record. Nurse #1 stated Resident #77 was discharged to the hospital on 4/4/21 and the advanced directives may have been sent with her and not returned.	F 578	F 578 Request Refuse Discontinue Treatment Formulate Advance Directives Advanced Directive for Resident #77 has had an order written and care plan has been updated. Advanced Directive for Resident #32 have been corrected and updated on Care Guide, in chart and in care plan. All residents have the potential to be affected by alleged deficient practice. Beginning on 07/05/2021 the Social Worker(s) completed an initial audit of advance directives to ensure advanced directives were developed and maintained throughout the medical record. The initial audit determined 63 of residents advanced directives were not updated consistently throughout the medical record. On 07/05/2021 the administrator and/or Staff Development Coordinator in-serviced the Interdisciplinary Team (IDT), including MDS nurses, on Code Status accuracy throughout the medical record. Advanced directives will be care planned. Advanced directives will be reviewed by the IDT (admissions, social worker,minimum data set (MDS) nurse, and/or DON/ADON/unit manager) upon admission, readmission, and at least annually.	

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F 578	Continued From page 19 During an interview with Social Worker #1 on 6/15/2021 at 5:32 pm she stated the Social Worker should discuss advanced directives of each resident, obtain an order from the physician for the residents requested advanced directives, obtain the appropriate documentation, and place the documentation on the medical record when they are admitted or readmitted. Social Worker #1 stated she was working on a plan of correction for the advanced directives currently but had not finished reviewing all the resident's medical records. Social Worker #1 stated she had worked at the facility for two weeks. An interview was conducted with Social Worker #2, who stated she no longer worked at the facility and left on 4/30/2021, and she stated she did not remember if she had obtained the order and documentation of Resident #77's advanced directives. The Administrator was interviewed on 6/17/2021 at 5:17 pm and she stated the advanced directives should be accurately recorded in Resident #77's medical record and the Social Worker is responsible for obtaining the orders and documentation for the advanced directives. The Administrator stated the facility had realized recently that there was an issue with the advanced directives not being included on the orders in the medical record. The Administrator stated the facility had a plan of correction started but had not educated the staff or completed the audit of all medical records. 2. Resident #32 was originally admitted to the facility on 8/16/19 and was most recently admitted on 4/10/21 after a hospitalization. The resident ' s	F 578	Beginning on 07/13/2021 the Social Worker(s) and/or nurse project leader or minimum data set (MDS) Coordinator will audit 10 records/week for three months for Code Status Accuracy. Results will be reported weekly to the IDT and monthly to Quality Assurance Performance Improvement (QAPI) Committee for review, root cause analysis, and need for additional monitoring.	

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cumulative diagnoses included stroke, chronic obstructive pulmonary disease (COPD), diabetes, weakness, chronic kidney disease, and pain.

Resident #32's most recent completed Minimum Data Set (MDS) assessment was a quarterly assessment and had an assessment reference date of 4/16/21. The resident was coded as having moderately impaired cognition.

The care plan for Resident #32 had a section called the Resident Care Guide. Under the heading of Advance Directives, the resident was listed as a Do Not Resuscitate (DNR), and the creation date of the Advance Directives was listed as 9/22/20. The care plan and the Resident Care Guide were documented as last having been reviewed on 5/3/21.

Resident #32's medical record contained a "Full Code Agreement" which would indicate the resident desire for cardiopulmonary resuscitation (CPR) to be initiated if his heart were to stop beating. The agreement was signed by the resident and dated 3/3/21.

A review of Resident #32's physician's orders revealed a physician ' s order dated 4/11/21 to establish the resident's code status as a full code.

An interview was conducted on 6/15/21 at 2:24 PM with Nurse #1. She stated Resident #32 was a full code after she consulted his medical record. She explained Resident #32 had been a DNR, but after a recent hospitalization, the resident elected to change his code status to full code. Upon reviewing the resident ' s care guide which documented the resident as a DNR, she stated it was incorrect because the resident was a full

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code. The nurse further stated she believed the resident ' s code status in the care guide would either be updated by medical records or the social worker.

During an interview conducted on 6/15/21 at 2:41 PM with the Medical Records Director she stated she did not update the resident care guide and she thought the social worker updated the care guide.

The Director of Nursing (DON) stated during an interview conducted on 6/15/21 at 2:48 PM the social worker was to update the resident care guide, but also the Minimum Data Set (MDS) nurse, or any nurse should have changed the resident ' s advance directives in the resident care guide when it changed. She said both of the current social workers had been recently hired and were not employed by the facility at the time of the Resident 32's readmission when his code status had changed. She further stated she expected for a resident's code status to be updated in the medical record when it was changed, the code status to be accurate throughout the medical record, and the resident's code status should match that of the resident's or the family member's wishes.

Resident #32 was interviewed on 6/15/21 at 4:18 PM. He stated he wanted full resuscitative efforts, or a full code, if his heart were to stop.

An interview was conducted with the Administrator on 6/17/21 at 1:20 PM. During the interview the Administrator stated due to her concern about the medical record being inconsistent with the code status for Resident #32 she had started a Performance Improvement

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F 578	Continued From page 22 Process (PIP) to make sure the code status for other residents were consistent throughout the medical record. She stated it was very important for each resident ' s code status to be consistent throughout the medical record and that was why she had initiated the PIP.	F 578		
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 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	F 580		7/31/21

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F 580	Continued From page 23 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 staff interviews the facility failed to notify a resident's representative of a resident's hospitalization for 1 of 1 resident reviewed for notification of changes (Resident #299). Findings included: Resident #299 was admitted to the facility on 3/12/21 with a diagnosis which included anxiety, and moderate protein calorie malnutrition. A Minimum Data Set (MDS) assessment dated 3/22/21 coded Resident #299 as being severely cognitively impaired. A record review revealed guardianship was granted for Resident #299 on 4/5/21.	F 580	F 580 Notify of Changes Resident #299 no longer resides in the facility. All residents have the potential to be affected by alleged deficient practice. On 07/07/2021 the social worker, admissions coordinator, and/or assigned project nurse completed a review of all discharges/transfers from the facility in the last 30 days to ensure that the resident□s representative has been notified of a resident□s hospitalization, accident, significant change in the resident□s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility.	

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F 580	Continued From page 24 A record review revealed that on 4/10/21 Resident #299 was noted to demonstrate unsafe behaviors which had resulted in a notification to the physician. The record review revealed the physician stated that Resident #299 should be sent out to the hospital for a psychiatric evaluation. On 4/10/21 a nursing note revealed Nurse #2 called 911 and the police and ambulance arrived at the facility and the resident was transported to the hospital. A record review revealed there was no evidence Resident #299's legal guardian was notified of the hospital transfer. An interview was completed with Nurse #1 on 6/16/21 at 3:08 PM who stated that if a resident was sent out to the hospital the staff should have looked at the face sheet and call the resident representative. A phone call was placed to Nurse #2 on 6/17/2021 at 12:31 PM who no longer works at the facility and was unable to be reached. An interview was completed with the Director of Nursing (DON) on 6/17/21 at 2:06 PM who stated staff need to call the resident representative if they are sent out to the hospital every single time. Every change needs to have a notification to the representative and it needs to be documented in the resident's record. If a staff cannot reach the resident representative this also needs to be documented. An interview was completed with the administrator on 6/17/21 at 4:10 PM who stated it is her expectation is that we are to notify all responsible parties when a resident is transferred to the hospital.	F 580	On 07/05/2021 the administrator, director of nursing (DON), staff development, social worker, and/or assigned project nurse began in-servicing nursing staff of the requirement to notify a resident□s representative when the resident is involved in a hospitalization, accident, a significant change in the resident□s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility. The in-service will be completed by 07/12/2021. Beginning 07/13/2021 the hall nurses, unit managers, weekend supervisor, assigned project manager, staff development, social worker, ADON, DON, and/or administrator is responsible for notification of changes. The physician/physician extender will be notified as soon as reasonably possible. Also, once the resident is safe, stabilized, and/or on the way to the hospital, the facility will begin making contact with the appropriate resident representative (the resident, legal guardian, appointed POA, resident representative, emergency contact, and/or resident preferred friend) of the resident's change in condition. Beginning 7/13/21 the social worker, admissions coordinator, administrator, and/or assigned project nurse will audit resident medical records weekly to ensure the resident□s representative has been notified of a resident'□s hospitalization, accident, significant change in the	

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F 580	Continued From page 25	F 580	resident□s condition, a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility. The audit will be documented on the F580 Notify of Changes audit tool. Beginning 7/13/21 the results of the audits will be discussed in the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	
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	F 656		7/31/21

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F 656	Continued From page 26 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the 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 record review and staff interviews the facility failed to develop a care plan for discharge plans for, 2 of 4 residents, Resident #77 and Resident #85, reviewed for discharge planning. Findings included: 1. Resident #77 admitted to the facility on 6/15/2017 with diagnoses of chronic kidney disease and pulmonary disease. The most recent Minimum Data Set (MDS) assessment, a quarterly assessment, dated 5/18/2021 revealed Resident #77 was cognitively intact.	F 656	F 656 Develop/Implement Comprehensive Care Plan Discharge care plans were completed for Resident #77 and Resident #85. All residents have the potential to be affected by the alleged deficient practice. The facility will review all residents□ care plans to ensure discharge care plans are in place. On 07/05/2021 the Administrator in-serviced the Interdisciplinary Team (IDT), including social worker(s), on developing and implementing a	

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F 656	Continued From page 27 Review of Resident #77 Care Plan dated 5/18/2021 revealed she did not have a discharge plan care plan. During an interview with Nurse #1 on 6/16/2021 at 5:22 pm she stated the Social Worker should develop a care plan for discharge plans for each resident. An interview was conducted with Social Worker #1 on 6/16/2021 at 5:32 pm and she stated she had only worked at the facility for 2 weeks and was not certain the Social Worker was responsible for completing the discharge plan care plans. Social Worker #2, the former social worker, was interviewed on 6/17/2021 at 1:47 pm and she stated she did not know who was responsible for the care plan for discharge plans and had not developed the discharge plan care plans for Resident #77. During an interview with the Administrator on 6/17/2021 at 5:17 pm she stated the Social Worker is responsible for implementing discharge plans on each resident's care plan. The Administrator stated she reviewed Resident #77's care plan and did not find a care plan for discharge plans. 2. Resident #85 admitted to the facility on 10/10/2018 with diagnoses of a seizure disorder and chronic pain. The most recent Minimum Data Set (MDS) assessment, a significant change assessment, dated 5/20/2021 revealed Resident #85 was	F 656	comprehensive person-centered care plan for each resident. The comprehensive care plan will include discharge planning. On 07/05/2021 the social worker(s) began auditing and updating resident care plans to ensure each resident has a developed care plan for discharge plans. The audit will be completed by 07/09/2021. On 07/05/2021 the social worker(s), nurse project coordinators, and/or MDS nurse(s) began auditing and updating resident care plans to ensure each resident has a comprehensive person-centered care plan for each resident. The audit will be completed by 07/12/2021. Beginning 07/13/2021 the social worker(s), nurse project coordinators, MDS nurse(s), and/or hall nurse will develop care plans, including discharge planning. Those care plans will be reviewed by the MDS nurse(s), ADON, DON, administrator, and/or the interdisciplinary team for timeliness and resident-centered appropriateness. The person-centered care plan, discharge planning, review will be consistent with the resident's objectives, practicable physical, mental, and psychosocial needs and desired outcomes. Discharge planning begins upon admission and will be initially documented by the social worker within the baseline care plan. Also the discharge plans will be reviewed, and updated if necessary, by the social worker or nursing staff as necessary or during	

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F 656	Continued From page 28 cognitively intact. The Care Plan dated 6/3/2021 was reviewed and no care plan was found discharge plans. During an interview with Social Worker #1 on 6/15/2021 she stated she was not sure who was responsible for ensuring there was a care plan for the resident's discharge plans. During an interview with Social Worker #2 on 6/17/2021 at 1:44 pm she stated she did not know who was responsible for putting Resident #85's discharge planning on his care plan and she had not developed the care plans. An interview was conducted with the Administrator on 5/17/2021 at 5:17 pm and she stated discharge plans should be included on each resident's care plans. The Administrator also stated the Social Worker was responsible for ensuring discharge plans were implemented.	F 656	quarterly reviews. Beginning 07/13/2021 the social worker(s), nurse project coordinators, MDS nurse(s), and/or IDT will audit 10 resident care plans/week to include all new admissions. The weekly audit will be completed for three months to ensure discharge care plans are in place. Results of the weekly audits will be reported weekly to the IDT and will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review, trending, and need for continued monitoring.	
F 684 SS=G	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 review, resident, staff and physician interviews, the facility failed to treat a	F 684	F 684 Quality of Care	7/31/21

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F 684	Continued From page 29 diabetic wound as ordered, resulting in the resident receiving antibiotic treatment, for one of one sampled resident (Resident #32) reviewed for wound care. Findings included: 1. Resident #32 was originally admitted to the facility on 8/16/19 and was most recently admitted on 4/10/21 after a hospitalization. The resident ' s cumulative diagnoses included stroke, chronic obstructive pulmonary disease (COPD), diabetes, weakness, right foot wound, chronic kidney disease, and pain. A review of Resident #32's physicians ' orders in his medical record revealed the following order dated 4/14/21 which read, right lateral foot-cleanse with wound cleanser, pat dry with a 4 inch by 4 inch gauze, apply a calcium alginate dressing 4 inch by 4 inch with silver to the wound bed, cover with 4 inch by 4 inch silicone border foam dressing, wrap with rolled gauze to hold in place, and change on Mondays, Wednesdays, Fridays, and as needed until healed. The care plan for Resident #32 had a focus area for at risk for skin breakdown related to diabetes. The focus area was most recently reviewed on 4/16/21. Further review of the care plan revealed a focus area with a created date of 6/6/21 for Actual Infection to the right foot diabetic ulcer. The interventions included an intervention to observer for signs/symptoms of infection to include increased temperature, loss of appetite, nausea, vomiting, diarrhea, myalgia (soreness of the muscles), headache, rash, cough, nasal congestion, change in mental status, increased confusion, etc. and notify physician for evaluation	F 684	Resident #32 wound is healed. All residents have the potential to be affected by the alleged deficient practice. The facility will review all residents with wounds to ensure they are receiving treatment and care in accordance with professional standards of practice. On 07/05/2021 the administrator in-serviced the Interdisciplinary Team (IDT) and nurses, including the treatment nurse, on providing quality care. The in-service noted that quality of care is a fundamental principal that applies to all treatment and care provided to the facility's residents. Based on the comprehensive assessment of the resident, the facility must ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. On 07/05/2021 the director of nursing (DON), the staff development coordinator (SDC), and/or assigned nurse project facilitators began in-servicing nursing staff on F 684 Quality of Care. The in-service specifically reviewed a root cause analysis of why the facility failed to treat a diabetic wound as ordered and how to promote future quality of care, including wound care. On 07/06/2021 the DON, SDC, and nurse project facilitators began auditing treatment administration records (TARs) and medication administration records	

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F 684	Continued From page 30 and/or intervention. Resident #32's most recent completed Minimum Data Set (MDS) assessment was a quarterly assessment and had an assessment reference date of 4/16/21. The resident was coded as having moderately impaired cognition and having a diabetic foot ulcer. Review of Resident #32's May Treatment Administration Records (TAR ' s) for the week of 5/24/21 through 5/28/21 revealed the following days with documentation of the prescribed wound care: An order undated treatment order which read, wound cleanser, cleanse right lateral foot, pat dry with a 4 inch by 4 inch gauze, apply a calcium alginate dressing 4 inch by 4 inch with silver to the wound bed, cover with 4 inch by 4 inch silicone border foam dressing, wrap with rolled gauze to hold in place, and change on Mondays, Wednesdays, Fridays, and as needed until healed. Monday, 5/24/21 and Wednesday 5/26/21 had a dash through them. Treatment was documented as provided on Thursday, 5/27/21, and Friday, 5/28/21. The other opportunities on Review of Resident #13's progress notes revealed a note dated Thursday, 5/27/21, and timed 11:40 AM revealed Nurse #4 documented when changing the resident ' s dressing to the right foot, noted that the site had purulent drainage (pus), skin intact, redness around the area was noted and a note was placed in the physician ' s book to evaluate. Further review of Resident #13's progress notes identified a note dated 5/27/21 and timed 2:20 PM indicating the resident ' s physician was	F 684	(MARs) to ensure each resident wound is being treated appropriately and medications are being administered as ordered. The audits will be completed by 07/12/2021. On 07/13/2021 the nurse project coordinators, SDC, and/or DON began three times weekly auditing to ensure each resident is receiving wound treatments as ordered. The three times weekly audits will be completed for three months to ensure wounds are treated as ordered. Results of the weekly audits will be reported weekly to the IDT and will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review, trending, and need for continued monitoring.	

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aware and had ordered intramuscular one-time antibiotic medication with oral antibiotic medication for 10 days. There were then subsequent orders on the same day for a referral to the local wound clinic and an appointment was made at the local wound clinic on 6/23/21.

Resident #13's physician's orders contained an order dated 5/27/21 which included referral to the wound care center, Cetrioxone (an antibiotic) 1 gram (gm) intramuscularly (IM) (an injection directly to a muscle) for one dose, and Cefalexin (an antibiotic) 500 milligrams (mg) orally four times a day.

There was a clarification physician's order for Resident #13, dated 5/27/21, which included the following Cetrioxone 1 gm IM for one dose may mix with lidocaine (a numbing medication) and Cefalexin 500 mg orally four times a day for 10 days for the left lateral (the outer side) foot wound infection.

Resident #13's Wound Ulcer Flowsheet dated 6/2/21 and timed 1:43 PM documented the resident ' s wound as having been a diabetic wound to the right foot, and measured 0.4 centimeters (cm) long, 0.5 cm long, and less than 0.1 cm deep, a scant amount of serosanguinous (drainage with a mixed fluid of blood and serum (yellow)) drainage, 100% epithelialized (the wound being covered with a base layer of healing tissue), a scant (small) amount of maceration (moisture to the skin), and to continue with the current treatment.

Resident #13 had a physician order dated 6/3/21 which included doxycycline monohydrate (an antibiotic) 100 mg orally twice a day for 14 days,

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discontinue Cefalexin, and obtain an x-ray of the right foot to rule out osteomyelitis.

Resident #13's Wound Ulcer Flowsheet dated 6/9/21 and timed 1:54 PM documented the resident ' s wound as having been a diabetic wound to the right foot, and measured 0.5 cm long, 0.7 cm long, and less than 0.1 cm deep, 100% granulation (healing skin), a scant amount of maceration (moisture to the skin), and to continue with the current treatment.

Review of Resident #32's June Treatment Administration Record (TAR) for the day of 6/14/21 revealed the following with documentation of the prescribed wound care: An order undated treatment order which read, wound cleanser, cleanse right lateral foot, pat dry with a 4 inch by 4 inch gauze, apply a calcium alginate dressing 4 inch by 4 inch with silver to the wound bed, cover with 4 inch by 4 inch silicone border foam dressing, wrap with rolled gauze to hold in place, and change on Mondays, Wednesdays, Fridays, and as needed until healed. The opportunity on Monday, 6/14/21 was blank.

During an interview conducted on 6/14/21 at 12:34 PM with Resident #32 he stated the dressing on his foot was supposed to have been changed Monday, Wednesday, and Friday, but when the Wound/Treatment Nurse was on vacation back in May it didn ' t get changed when it was supposed to.

Review of Resident #32's medical record revealed a physician progress note from the wound physician dated Tuesday, 6/15/21. The note documented the resident ' s dressing for his right foot wound hadn ' t been changed since

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Friday, 6/11/21. The note further documented the resident denied fevers/chills, the wound was very macerated (presence of excessive moisture on the skin) with callus, and the dressing would be changed to a soft cast that is to be changed weekly at the wound clinic.

An interview was conducted on 6/15/21 at 4:45 PM with the Wound/Treatment Nurse. She said the resident ' s wound was healing and was very small, but the resident was insistent upon going to the wound clinic. She said the resident had been to the wound clinic on the date of the interview and had returned with a dressing which was not to be removed by the facility, but by the wound clinic during the resident ' s next appointment, the following week. She said the resident ' s dressing would often become soiled because the resident was ambulatory, and he would also get his dressings wet somehow.

A second interview and a record review were conducted with the Wound/Treatment Nurse on 6/16/21 at 4:25 PM. During the interview she stated she was on vacation from 5/22/21 to 5/29/21 and when she was off, or assigned to a hall, the nurses on the floor were responsible for conducting the treatments on their own for the residents on their hall. She reviewed the May 2021 TAR and stated the dashes for Resident #13 ' s wound treatment on 5/24/21 and 5/26/21 indicate the dressing was not changed or not documented as being changed. She said Nurse #4 had been on Resident #13 ' s hall while she was on vacation and would have been responsible to change the dressing. She further stated there was a medication aide on the cart on 5/24/21 but Nurse #4 would still be responsible to change the treatments on the hall, including the

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F 684	Continued From page 34	F 684		

dressing change for Resident #32. Regarding Monday, 6/14/21, she had been assigned to pass medications on another hall and she could not pass the medications and do the treatments. She explained it would have been Nurse #5's responsibility to have completed the dressing change on Resident #32 on 6/14/21. She reviewed the June 2021 TAR for Resident #32 and stated the dressing change for 6/14/21 had not been initialed, which indicated the dressing change had not been completed. She explained all of the nurses on the halls were aware to do their own dressing changes on Monday, because she was on the hall passing medications. The Wound/Treatment Nurse stated the dressings should have been applied as ordered.

A phone interview was conducted with Nurse #4 on 6/17/21 at 8:26 AM. During the interview the nurse stated she did not remember if she did or did not do the dressing for Resident #32 on 5/24/21 or 5/26/21. She said she was overseeing a medication aide on one of those days and it was very busy. She further stated she did change the dressing on 5/27/21, had informed the physician of the condition of the wound, and had obtained an order for antibiotics.

During an interview with Nurse #5 conducted on 6/17/21 at 8:45 AM she stated she had not changed the dressing for Resident #32 on Monday, 6/14/21, because she believed there was a treatment nurse that day.

A second interview and an observation were conducted with Resident #32 on 6/17/21 at 8:46 AM. The resident was observed to have a bandage wrapped around his right foot, which was covering his whole foot. The resident stated

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	345144	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE HEALTH AND REHABILITATION CENTER	706 PINEYWOOD ROAD THOMASVILLE, NC 27360

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F 684	Continued From page 35 after the dressing on his foot was not changed on 5/24/21 and 5/26/21, it wasn ' t until 5/27/21 the dressing was changed, and the doctor did not look at it that day, but he was started on antibiotics. The resident further stated the dressing had not been changed since 6/11/21 until 6/15/21, and it was at the wound clinic where the dressing change was completed. He explained the dressing change, which was ordered Monday, Wednesday, and Friday, was missed on Monday 6/14/21. During an interview conducted on 6/17/21 at 9:47 AM with the resident's physician he stated he had ordered the dressings for Resident #32 prior to him going to the wound clinic. He stated it was his expectation for his dressing change orders to be followed and had confidence in the Wound/Treatment Nurse providing resident care and dressing changes as ordered. The physician further explained he did not believe there would be a negative outcome related to the dressing having not been changed because the wound was so small. An interview was conducted with the Director of Nursing on 6/17/21 at 12:43 PM. She stated in the event the Wound/Treatment Nurse could not do the treatment, the nurses on the floor are responsible for their treatments. She further stated the ordered dressings and treatments should be completed as ordered. The Administrator stated during an interview conducted on 6/17/21 at 1:20 PM treatments should be provided as ordered regardless of if there is Wound/Treatment Nurse or not.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		7/31/21

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F 812	Continued From page 36 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean food service equipment and allow steam table pans to air dry after sanitation. The facility failed to maintain clean contact surface on fifteen of sixteen knobs on two food preparation appliances observed for cleanliness (steam table and stove). The facility failed to allow 20 of 28 steam table pans to air dry. Findings Included: 1. An observation of the kitchen conducted on 6/14/21 at 10:00 AM revealed the following: a. Ten of ten knobs on the ten-burner stove and five of six knobs on the steam table were observed to have had a buildup of grease, dirt,	F 812	F812 Food Procurement Store Prepare Serve Sanitary 06/18/2021 all steam table pans were removed, cleaned and air dried. All knobs on steam table and on stove were cleaned of grease, dirt, and debris by Dietary Manager All residents have the potential to be affected by the alleged deficient practice. On 6/18/2021 an audit was completed for sanitation and dryer procedures to ensure all dishes are air dried properly and kitchen is cleaned and sanitized by	

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F 812	Continued From page 37 and debris. b. Twenty of twenty-eight steam table pans were observed to have been nested and stacked with moisture in between the pans on a rack. Adjacent to the rack where the pans were stacked was observed another rack which had signage directing staff members to allow the pans to air dry on that rack prior to placing them on the other rack for storage. The Dietary Manager was present during the observation and immediately removed the nested wet pans, and informed one of the dietary staff members to wash the pans. 2. An observation of the kitchen conducted on 6/16/21 at 11:28 AM revealed the following: a. Ten of ten knobs on the ten-burner stove and five of six knobs on the steam table were observed to have had a buildup of grease, dirt, and debris. An interview and observation that was conducted with the Dietary Manager (DM) on 6/17/21 at 11:09 AM. The observation revealed the Ten of ten knobs on the ten-burner stove and five of six knobs on the steam table were observed to have had a buildup of grease, dirt, and debris. The DM stated the knobs appeared as they needed to be cleaned and stated there was a buildup on the knobs. The DM further stated he believed the issue with the steam table pans having been stacked wet related to the pans having been stacked wet at the end of the shifts. He said he had initiated a shift to shift rotation for steam table pans which will be allowed to air dry, before the next shift stacks them for storage. An interview was conducted with the Administrator on 6/17/21 at 1:20 PM. During the interview the Administrator stated pans should be	F 812	Dietary Manager. On 07/01/2021- 7/26/2021 there is an in-service of all Dietary Managers, Dietary Aides and Dietary Cooks on sanitation and cleanliness of equipment and appropriate air drying of steam table pans and other cookware. The in-service was conducted by the administrator=, staff development, dietary consultant, or corporate facility consultant. The in-service will be documented on paper and include a walk through of the kitchen and hands on demonstration. The in-service has been added to the orientation of new employees. New employees will not work independently until they have had the in-service from a dietary manager(s), head cook, or staff development. The training for new staff will also be on sanitation and cleanliness of equipment, appropriate air drying of steam table pans and other cookware, and documented on paper and include a walk through of the kitchen and hands on demonstration. By 7/26/2021 the Dietary Manager will have a cleaning schedule for daily sanitation and cleanliness of equipment and daily air drying of cleaned pans and cookware. On 7/26/21 a dietary manager(s) will audit sanitation and cleaning of kitchen equipment including knobs on stove and steam table according to appropriate sanitation guidelines 5x/week x3 months	

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F 812	Continued From page 38 allowed to air dry before stacking and knobs on appliances should be cleaned as part of routine cleaning.	F 812	to ensure compliance. Dietary Manager will audit all steam pans and cookware for wet nesting 5x/week x3 months to ensure compliance. Results of audit will be taken to QAPI Committee for review and trending. The QAPI committee will review the results of the audits for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring and make recommendation for monitoring for continued compliance.	