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E 000	Initial Comments An unannounced recertification survey was conducted 2/14/22 through 2/17/22. The facility was found out of compliance with the requirement CFR 483.73, Emergency Preparedness at E0004. See Event ID #2BPO11.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an	E 004		3/29/22

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

Electronically Signed | 03/10/2022

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E 004	Continued From page 1 all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: The facility's EP Plan was reviewed which was signed by a previous Administrator and dated 5/29/20. An interview with the Administrator was conducted on 2/17/22 at 12:40 PM. He indicated he had been acting as the interim Administrator since December 2021 and had not reviewed the EP manual. He commented that he didn't know why the previous Administrators had not updated the EP book.	E 004	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Administrator updated Emergency Operations Plan (EOP) with current key personnel, employee phone list, and current vendors on 3/1/2022. EOP Plan reviewed at standup meeting on 3/2/2022 with IDT. 2. On 3/1/2022, the Administrator was educated on 3/1/2022 regarding requirement for annual review and update of the EOP by the Inter-disciplinary Team	

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E 004	Continued From page 2	E 004	(IDT) by the Regional Director of Operations (RDO.) 3. IDT was educated regarding facility requirement to review and update EOP annually by the RDO on 3/11/2022. 4. Administrator will monitor new changes established by rule or regulation and discuss with IDP as needed. The facility will incorporate necessary changes in the EOP after review by the IDT. RDO will monitor annually to ensure sustained compliance.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/14/22 to 2/17/22. Event ID #2BPO11 13 of the 29 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=E	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.	F 550		3/29/22

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F 550	Continued From page 3 §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 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 observations, residents and staff interviews and record review, the facility failed to treated residents in a dignified manner by not responding to call lights resulting in feeling of anger and frustration. This was for 5 (Resident #31, Resident #4, Resident #26, Resident # 29 and Resident #54) of 5 residents reviewed for dignity. The findings included 1. Resident #31 was admitted on 1/27/16 with a diagnosis of Cerebral Vascular Accident (CVA) with left sided hemiplegia.	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550	

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F 550	Continued From page 4 Resident #31's quarterly Minimum Data Set (MDS) dated 1/30/22 indicated he was cognitively intact, exhibited no behaviors and coded as independent to total staff assistance with his activities of daily living (ADLs). Resident #31's revised care plan dated 1/18/21 indicated he required staff assistance with his ADLs. Interventions included encouraging him to use his call light for assistance. Review of a resident council communication form dated 1/20/22 read Resident #31 complained about being left sitting up in his wheelchair too long. The form read Resident #31 was reminded to use his call light rather than yelling out to staff to be put to bed. An interview was conducted with Resident #31 on 2/14/22 at 11:55 AM. He stated he frequently had to wait sometimes for up to an hour for staff assistance after pressing his call light. He stated this has been a problem for months and he had mentioned it during a resident council meeting. He stated if he did not yell out to staff, they would not know he wanted to go back to bed. He stated it made him very angry. Resident #31 pressed his call light. The call light system in the room and in the bathroom did not make an audible sound. During an observation on 2/14/22 at 12:30 PM, Resident #31's call light was observed on. Nursing Assistant (NA) #4 was observed entering his room at 12:57 PM and turned off the call light. She asked Resident #31 what he needed, and he stated that we were testing out his call light. An interview was conducted on 2/14/22 at 1:00 PM with NA #4. She stated she was an agency	F 550	The facility failed to treat residents in a dignified manner by not responding to call lights in a timely manner. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/17/2022 resident #31, #4, #26, #29 and #54 were given hand bells to use in addition to their call lights by the Director of Nurses. They were instructed to use both to alert staff to the need for assistance. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 2/17/2022 the Director of Nurses and Nursing supervisor provided residents, in addition to their call light, a hand bell to be used if staff assistance was needed. In addition hourly rounding of all residents was initiated on 3/ 11/2022 by the assigned hall nurses, certified nursing assistant's, Registered Nurse Manager and Support Nurse and education was initiated by the Director of Nurses and Nurse Consultant on the process. Hourly rounding is to occur on all shifts and days of the week until the call light system is fully functional. An hourly rounding log was created to document the rounding and any areas of concern that need addressing and will be reviewed daily Monday through Friday as part of Daily Stand Up, which is attended by all department managers and the facility administrator. All new admissions will be provided a hand bell in addition to their	

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aide and had been working at the facility since November 2021. She stated the call light system has never made an audible sound and staff would need to be on the 300 hall to observe the light above a resident's door. NA #4 stated the residents have voiced long call light wait times and she felt it was due to the call light system not sounding. She stated management was aware of the problem to her knowledge.

During an observation on 2/16/22 at 3:47 PM, a small bell was observed on Resident #31's bed side table. He stated staff provided him with the bell a few minutes ago and told him to use the bell if staff did not respond timely.

An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated the facility passed out the bells on 2/16/22 to assist residents with calling for staff assistance. He stated he was new to the facility and aware that the call light system did not have any sound. He stated apparently the system went down in August 2021, but the staff had been doing 10 minutes rounds on each hall to ensure timely call light responses for the residents since he came to the facility as the interim Administrator in December 2021. He stated timely call light response was a dignity concern and the facility had implemented measures to avoid prolonged delays.

2. Resident #4 was admitted on 10/19/21 with a diagnosis of Cerebral Vascular Accident (CVA) with left sided hemiplegia.

Review of Resident #4's quarterly Minimum data Set dated 11/10/21 indicated he was cognitively

call light and will also be rounded on hourly.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 3/09/22, the Director of Nurses and Nurse Consultant, RN Supervisor began education of all full time, part time, as needed, agency nurses and CNA's, department managers, housekeeping, activities and therapy staff on facility policy on assuring that residents are rounded on hourly and call devices answered timely, along with applicable resident rights related to dignity. Education will be completed by 3/28/22 at which time all of the above must be in-serviced prior to working.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or Designee will monitor compliance utilizing the F550 Resident Rights Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents are being rounded on hourly, they have access to a call device and that their dignity is being maintained as it pertains to the timely response to the need for staff assistance. The administrator/designee will monitor that residents are being

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F 550	Continued From page 6 intact, exhibited no behaviors and coded as independent to extensive staff assistance with his activities of daily living (ADLs). Resident #4's comprehensive care plan last revised 1/25/22 did not include a care plan for staff assistance with his activities of daily living (ADLs). Review of a resident council communication form dated 1/20/22 read Resident #4 and told by a staff member not to put his call light on again Resident #4 was in attendance of a Resident Council meeting on 2/15/22 at 10:00 AM. He stated he mentioned his concerns in the last resident council meeting about long call light wait times, but nothing has changed. He stated it was very frustrating when there was no improvement or follow up about why it took to staff so long to respond to call light. During an observation on 2/16/22 at 8:30 AM, Resident #4's call light was observed on. There was no audible sound. Nursing Assistant (NA) #1 answered his call light at 9:10 AM. She stated he requested to get up out of bed and into his wheelchair. NA #1 stated unless you were on the 200 hall, you would not know a resident had pressed their call light. She stated the delay was also due to the breakfast trays being on the 200 hall. During an observation on 2/16/22 at 4:27 PM, a small bell was observed on Resident #4's bed side table. He stated staff provided him with the bell earlier this afternoon and told him to use the bell if staff did not respond timely.	F 550	treated in a dignified manner by auditing resident satisfaction with call bell response time weekly x 2 and monthly x 3. This will include auditing 4 alert residents on various halls and contacting 2 Responsible Parties for those residents with a Brief Interview for Mental Status below 13. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated the facility passed out the bells on 2/16/22 to assist residents with calling for staff assistance. He stated he was new to the facility and aware that the call light system did not have any sound. He stated apparently the system went down in August 2021, but the staff had been doing 10 minutes rounds on each hall to ensure timely call light responses for the residents since he came to the facility as the interim Administrator in December 2021. He stated timely call light response was a dignity concern and the facility had implemented measures to avoid prolonged delays.

3. Resident #26 was admitted 3/5/21 with a diagnosis of paraplegia.

Review of Resident #26's quarterly Minimum Data Set (MDS) dated 1/2/22 indicated he was cognitively intact and exhibited the behaviors of rejection of his care. He was coded as independent to extensive staff assistance with his activities of daily living (ADLs).

Resident #26's revised care plan dated 3/11/21 indicated he required staff assistance with his ADLs. Interventions included encouraging him to use his call light for assistance.

An interview was conducted with Resident #26 on 2/14/22 at 10:44 AM. He stated the facility did not have enough staff because he had long wait times for staff assistance when pressing his call light. He stated it was ridiculous to have to wait up 2 hours for staff assistance. Resident #26 endorsed anger and frustration. The call light system in the room and in the bathroom did not

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make an audible sound.

During an observation on 2/16/22 at 11:00 AM, Resident #26's call light was observed on. There was no audible sound. At 12:18 PM, Nursing Assistant (NA) #5 was observed answering his call light.

An interview was conducted on 2/16/22 at 12:20 PM with NA #5. She stated she was aware that some residents were upset over long waits for responses to call lights. She stated she tried to round on her halls every 10 minutes or so but during meals and morning ADLs, she was unable to ensure call lights were answered timely. NA #5 stated the call light system lost the audio feature sometime last summer and that management was aware.

During an observation on 2/17/22 at 8:20 AM, a small bell was observed on Resident #26's bed side table. He stated staff provided him with the bell yesterday and told him to use the bell if staff did not respond timely.

An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated the facility passed out the bells on 2/16/22 to assist residents with calling for staff assistance. He stated he was new to the facility and aware that the call light system did not have any sound. He stated apparently the system went down in August 2021, but the staff had been doing 10 minutes rounds on each hall to ensure timely call light responses for the residents since he came to the facility as the interim Administrator in December 2021. He stated timely call light response was a dignity concern and the facility had implemented measures to avoid prolonged

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delays.

4. Resident #29 was admitted on 7/6/17 with a diagnosis of Cerebral Vascular Accident (CVA) with right sided hemiplegia.

Review of Resident #29's annual Minimum Data Set (MDS) dated 1/5/22 indicated moderate cognitive impairment, no behaviors and supervision to total staff assistance with his activities of daily living (ADLs).

Resident #29's revised care plan dated 2/27/21 indicated he required staff assistance with his ADLs. Interventions included encouraging him to use his call light for assistance.

An interview was conducted with Resident #29 on 2/14/22 at 11:06 AM. He stated he frequently had to wait sometimes for up to an hour for staff assistance after pushing his call light. He stated this has been a problem for months and it frustrated him that there was no improvement. Resident #26 pressed his call light. The call light system in the room and in the bathroom did not make an audible sound. Nursing Assist (NA) #4 responded within 5 minutes.

An interview was conducted on 2/14/22 at 1:00 PM with NA #4. She stated she was an agency aide and had been working at the facility since November 2021. She stated the call light system has never made an audible sound and staff would need to be on the 300 hall to observe the light above a resident's door. NA #4 stated the residents have voiced long call light wait times and she felt it was due to the call light system not sounding. She stated management was aware of the problem to her knowledge.

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During an observation on 2/17/22 at 9:30 AM, a small bell was observed on Resident #29's bed side table. He stated staff provided him with the bell yesterday and told him to use the bell if staff did not respond timely.

An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated the facility passed out the bells on 2/16/22 to assist residents with calling for staff assistance. He stated he was new to the facility and aware that the call light system did not have any sound. He stated apparently the system went down in August 2021, but the staff had been doing 10 minutes rounds on each hall to ensure timely call light responses for the residents since he came to the facility as the interim Administrator in December 2021. He stated timely call light response was a dignity concern and the facility had implemented measures to avoid prolonged delays.

5) Resident #54 was admitted to the facility on 9/1/17 with diagnoses that included congestive heart failure (CHF), glaucoma and diabetes type 2.

Resident #54's active care plan, last reviewed 12/6/21, included a focus area for Activities of Daily Living (ADL) self-care performance deficit. The interventions included to encourage use of the call light for assistance.

A quarterly Minimum Data Set (MDS) assessment dated 1/26/22 indicated Resident #54 was cognitively intact and required extensive to total assistance from staff for ADL's.

On 2/14/22 at 9:30 AM, Resident #54 was

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observed to be holding the call light close to his chest and stated "this is my life line if I need something" but in the past "few" months he had been waiting longer for staff assistance when the call light was turned on. Resident #54 explained he had visual deficits and relied on his hearing, to which, he had noticed, along with the wait time, had stopped hearing the audible sound as well. Resident #54 stated due to his visual deficit the wait time felt like an "eternity" but was more like 45 minutes to an hour most of the time.

On 2/14/22 at 11:06 AM, Resident #54's call light was observed on with no audible sound only a light visible at the top of the room's door in the hallway. Nursing Assistant (NA) #4 responded within 5 minutes.

An interview was conducted on 2/14/22 at 1:00 PM with NA #4 who explained she was an agency aide and had been assisting the facility since November 2021. She stated the call bell system had never made an audible sound since she had been working at the facility and staff would need to be on the specific hallway or at the nurses' station to observe the light above Resident #54's door was on. NA #4 further stated the residents had voiced long call light wait times which she felt was due to the call light system not sounding and management was aware of the issue.

The Registered Nurse (RN) supervisor was observed providing Resident #54 a small silver bell with a long black handle on 2/16/22 at 3:45 PM. She was heard telling Resident #54 to use the bell for assistance due to the poorly functioning call light system. Resident #54 was observed holding both the call light and silver bell close to this chest.

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F 550	Continued From page 12 An interview occurred with the Administrator on 2/17/22 at 10:35 AM, who explained the facility passed out the silver hand bells on 2/16/22 to assist residents with calling for staff assistance. He stated he had been acting as the interim Administrator since December 2021 and was aware the call light system did not have sound, but the staff had been doing 10-minute rounds on each hall to ensure timely call light responses while he was getting the system repaired. The Administrator added timely call light response was a dignity concern and felt the facility had implemented measures to avoid prolonged delays.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to assess whether the self-administration of medications was clinically appropriate for 2 of 2 sampled residents (Residents #1&#46) who were observed to have medications at bedside. Findings included: 1. Resident # 1 was admitted to the facility on 1/25/21 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 11/3/21 indicated that Resident #1's cognition was intact.	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F 554 The facility failed to assess whether the	3/29/22

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F 554	Continued From page 13 Review of Resident #1's medical records including physician's orders, assessments and care plan, revealed no order to leave the medications at bedside and there was no assessment and care plan for self-administration of medications. Resident #1 had a physician's order for Tylenol (used to treat aches and pains) 325 milligrams (mgs) tablet - give 3 tablets three times a day for pain. Resident #1 was observed up in wheelchair in her room eating lunch on 2/14/22 at 1:10 PM. On top of the over the bed table, there was a medicine cup observed with 3 white colored tablets. When interviewed, Resident #1 stated that the tablets were Tylenol. She reported that the Nurse usually left them for her to take after lunch. Nurse #3, assigned to Resident #1, was interviewed on 2/14/22 at 1:15 PM. She verified that she was the nurse who administered the Tylenol to Resident #1. She indicated that she usually left the Tylenol at bedside for the resident to take after she finished eating her lunch. The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as the MDS Nurse 4-5 months ago. She stated that Resident #1 was not assessed for self-administration of medications. The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. The DON stated that she expected the nurses not to leave medications at bedside unattended.	F 554	self-administration of medications was clinically appropriate for resident #1 and #46 who had meds at bedside. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #46 the Director of Nurses completed a self- administration assessment on 2 /23/2022 and a physician order was obtained to keep the med at bedside and the resident was educated by the Director of Nurses. The medication was removed from the bedside on 2/14/2022 by the nurse manager. For resident #1 the medication was removed from bedside on 2/14/2022 and a physician order was obtained for the medication to be administered on a per need basis rather than a scheduled basis. The resident was educated on the change to PRN availability by the Director of Nurses. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/04/2022 the RN Supervisor audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no other residents who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/09/2022 the Director of Nurses, RN	

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F 554	Continued From page 14 2. Resident #46 was admitted to the facility on 1/10/22 with multiple diagnoses including anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 11/3/21 indicated that Resident #46's cognition was intact. Resident #46 did not have an assessment or care plan to self-administer medications. Resident #46 had a physician's order dated 1/10/22 for Calcium Carbonate (Tums) (a calcium supplement) 750 mgs by mouth twice a day (9AM & 5 PM). Resident #46 was observed in bed with eyes closed on 2/14/22 at 1:12 PM. On top of the over the bed table, there was a medicine cup observed with 2 colored tablets. When interviewed, Resident #46 stated that the tablets were Tums. She reported that the Nurse usually left them for her to take. Nurse #3, assigned to Resident #46 was interviewed on 2/14/22 at 1:15 PM. She stated that she was not the Nurse who passed the morning medications for Resident #46. She observed the medications at bedside and confirmed that they were Tums. Nurse #3 denied leaving Resident's 46 medications at bedside. The Support Nurse was interviewed on 2/14/22 at 1:16 PM. She verified that she was the nurse who passed the morning medications for Resident #46. She denied leaving the Tums at resident's bedside. She indicated that it might be the night shift who left the Tums at bedside, but she did not notice them that morning.	F 554	Supervisor and Nurse Consultant began education of all Full Time, Part Time, PRN and agency nurses on facility policy related to medication safety that included resident assessment for self -administration of medication process and safely securing and storing medications. Education will be completed by 3/28/2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits will be done weekly for 2 weeks, then monthly for 3 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be	

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F 554	Continued From page 15 The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as the MDS Nurse 4-5 months ago. She stated that Resident #46 was not assessed for self-administration of medications. The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. The DON stated that she expected the nurses not to leave medications at bedside unattended.	F 554	presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, acting Residential Care Coordinator, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to place a resident's call light within reach for 1 of 22 residents reviewed for accommodation of needs (Resident #35). The findings included: Resident #35 was admitted to the facility on 2/12/20 with diagnoses that included cerebral palsy, asthma, and restless leg syndrome. A nursing progress note dated 1/20/22 revealed Resident #35 was alert and oriented and able to	F 558	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F558	3/29/22

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F 558	Continued From page 16 make her needs known. She required extensive assistance with the completion of Activities of Daily Living (ADL) tasks. A quarterly Minimum Data Set (MDS) assessment dated 1/31/22 indicated Resident #35 was cognitively intact and required extensive assistance with bed mobility and toileting. Resident #35's care plan, last reviewed 2/1/22, included the following focus areas: - Actual fall with risk for more due to poor balance/unsteady gait. The interventions included to ensure the call light was within reach. - ADL self-performance deficit related to cerebral palsy. The interventions included to encourage use of call light to call for assistance. On 2/14/22 at 9:40 AM, an observation occurred of Resident #35 while she was lying in bed. The call light was under her bed out of reach. Resident #35 stated the call light was there most of the time and she would yell out when she needed something. Another observation was made on 2/15/22 at 9:28 AM. Resident #35 was in her bed working on word puzzles. Her call light was under the bed out of reach. When asked how she would request assistance, she stated she would let staff know when they entered the room, when they were passing by or by yelling out for assistance. Resident #35 was observed on 2/15/22 at 12:03 PM, sitting up in a wheelchair in her room. The call light was observed to be under her bed out of reach. On 2/16/22 at 8:29 AM, Resident #35 was	F 558	The facility failed to place a call light within resident reach. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/17/2022 resident #35 call light was placed within resident's reach by the Registered Nurse Supervisor. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 3/04/2022 the RN supervisor audited all residents for reachable access to a call device with no other concerns found. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/09/22, the Director of Nurses and Nurse Consultant, RN Supervisor began education of all full time, part time, PRN, agency nurses and CNA's, administrator, housekeeping, activities and therapy staff on facility policy on assuring that residents have reachable access to a call device to notify staff that they need assistance. Education will be completed by 3/28/22 at which time all of the above must be in-serviced prior to working. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 558	Continued From page 17 observed sitting in her bed completing a word puzzle. The call light remained under the bed out of reach. Nurse Aide (NA) #4 was interviewed on 2/16/22 at 2:00 PM and indicated she worked with an agency and had been assisting at the facility since November 2021. She was assigned to the resident and indicated she noticed the call light was under Resident #35's bed, retrieved it and placed it within reach. NA #4 was unable to state why the call light had been under Resident #35's bed since 2/14/22. The Director of Nursing was interviewed on 2/17/22 at 5:33 PM, and stated it was her expectation for call lights to be within reach of all residents, at all times.	F 558	The Director of Nurses or Designee will monitor compliance utilizing the Call Device Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents are able to access a reachable call device to request staff assistance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		3/29/22

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F 561	Continued From page 18 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to honor residents' choices related to showers and shampoos. This was for 3 of 4 residents reviewed for choices (Residents #35, #44 and #1). The findings included: 1) Resident #35 was admitted to the facility on 2/12/20 with multiple diagnoses that included cerebral palsy, osteoarthritis, and restless leg syndrome. The annual Minimum Data Set (MDS) assessment dated 1/12/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower. A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and displayed no behaviors or rejection of care. She	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561 The facility failed to provide showers for the below residents: 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022. For resident #44, on 03/03/2022 the	

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F 561	Continued From page 19 required limited assistance with personal hygiene and extensive assistance with bathing and dressing. Limited range of motion was present to both upper extremities. Resident #35's active care plan, last reviewed on 2/1/22, included a focus area for "Activities of Daily Living (ADL) deficit related to disease process". The interventions included to offer choices in daily care. A review of Resident #35's medical record revealed she had scheduled showers on Tuesday and Friday evenings (3:00 PM to 11:00 PM shift). Nursing progress notes were reviewed from 9/1/21 to 2/15/22 and did not reveal any refusals for showers or bathing assistance. A review of Resident #35's Nursing Assistant (NA) bathing/shower documentation and facility shower sheets from 9/25/21 to 2/15/22 indicated Resident #35 refused a shower and requested a bed bath on her scheduled shower days of Tuesday and Friday on 10/15/21 and 10/22/21. The NA documentation revealed she had received a scheduled shower on 10/19/21, 11/9/21, 11/30/21, 12/3/21 and 12/31/21. An interview occurred with Resident #35 on 2/14/22 at 9:40 AM, who stated she would like to receive her scheduled showers and shampoos twice a week. Resident #35 explained it had been "a while" since she had received a shower/shampoo, only receiving a bed bath instead. She stated she required assistance with washing her lower legs, back, shoulders and hair. Resident #35 stated her scheduled shower days were Tuesday and Friday in the evening and she would like to have them completed as scheduled.	F 561	Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was offered and refused on 3/ 4 /2022 and 3/08/2022. Bed baths were provided by nursing staff. For resident # 1, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday day shift. A shower/shampoo was offered on 3/04/2022 and 3/08/2022 and refused by the resident. Bed baths were provided by staff. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 02/24/2022 the Nurse Manager interviewed all current alert and oriented residents for their preference regarding shower days. The Director of Nurses /MDS nurse will then task the requested shower schedule to PCC task to fire to the CNA's for documentation. This will be completed by 03/04/2022. For current non-alert and oriented residents, the Certified Nursing Assistant's were educated by the nurse manager on the new facility shower schedule and that it should be followed as posted. Showers will be documented in the personal care task of Point Click Care. This will be completed by 03/04/2022. All residents will receive a shower and shampooing of hair by 3/16/2022 based on their preferences and shower	

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F 561	Continued From page 20 Resident #35's hair was unbrushed and had a greasy appearance. On 2/15/22 at 3:43 PM, Resident #35 was sitting up in a wheelchair in the hallway and stated she was to get her shower this evening. Resident #35 was interviewed on 2/16/22 at 8:29 AM. She was lying in bed working on a word puzzle. She stated she didn't receive her shower/shampoo as scheduled last night but received a bed bath instead. Stated the NA had no response when she asked why she couldn't get a shower. On 2/16/22 at 2:00 PM an interview occurred with NA #4. She explained she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. NA #4 was familiar with Resident #35 and stated bed baths were provided to her since she refused her showers. Stated she would use a washcloth to provide shampoos when bed baths were provided. An interview occurred with NA #3 on 2/16/22 at 3:55 PM. She worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #35 but was not assigned to care for her often. NA #3 could not recall Resident #35 refusing scheduled showers and preferred to get them before dinner was served. NA #3 had documented a shower was provided to Resident #35 on 12/31/21. A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM. She explained she worked both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts, worked through an agency and	F 561	schedule unless they refuse. If they refuse a bed bath will be provided by nursing and showers/shampoos will continue to be offered following their preference and shower schedule> The responsible will be notified of refusals. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/09/2022 Director of Nurses, Nurse Consultant and the Nurse Manager began education to all full time, part time, PRN and agency Nurses and CNA's on the following: • New revised shower schedule • Refusal documentation • Documentation of completion in PCC tasks. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 561	Continued From page 21 had been assisting the facility for 2 months. She was familiar with Resident #35 and stated she was most often assigned to care for her when she worked. NA #12 stated she only provided bed baths and not showers, as she was unsure what kind of transfer assistance was needed for the residents. NA #12 could not recall any refusals of care by Resident #35. On 2/17/22 at 5:33 PM, an interview was held with the Director of Nursing (DON) who had been employed at the facility since January 2022. She felt the lack of accountability could be to blame for not providing scheduled showers. The DON added she expected showers to be provided/offered on the scheduled shower days and if a resident refused there should be documentation on both the NA documentation as well as nursing progress notes. 2) Resident #44 was originally admitted to the facility 11/10/20 with diagnoses that included diabetes type 2, chronic obstructive pulmonary disease (COPD), and low back pain. The annual Minimum Data Set (MDS) assessment dated 10/17/21, revealed it was somewhat important to choose between a bed bath or shower. A quarterly MDS assessment dated 1/17/22 indicated Resident #44 was cognitively intact and displayed no behaviors or rejection of care. She required limited assistance with dressing and extensive assistance with bathing. Resident #44's active care plan, last reviewed on 2/1/22, included a focus area for "Activities of	F 561	and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor shower compliance. The Social Worker or designee will monitor satisfaction with showers weekly x 2 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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Daily Living (ADL) self-care performance deficit related to general deconditioning". The interventions included to avoid scrubbing and pat dry sensitive skin, preference of showers, staff assistance with grooming and personal hygiene and offer choices in daily care.

A review of Resident #44's medical record revealed she had scheduled showers on Tuesday and Friday evenings (3:00 PM to 11:00 PM shift). Nursing progress notes were reviewed from 10/1/21 to 2/15/22 and did not reveal any refusals for showers or bathing assistance.

The Director of Nursing (DON) provided the following Nursing Assistant (NA) facility shower sheets for Resident #44, regarding scheduled showers for Tuesday and Friday evenings, for the time period of 10/1/21 to 2/15/22:
- Friday 10/22/21- noted as refused with no indication of a bath provided.
- Tuesday 2/1/22- noted as refused with no indication of a bath provided.
- Tuesday 2/15/22- noted as refused bath and stated she does her own. There was no indication of a bath provided.
The DON stated she could not location any other documentation regarding Resident #44's showers or bathing.

An interview occurred with Resident #44 on 2/14/22 at 11:15 AM, who stated she could not "remember the last time she had a shower, or her hair washed". She stated her scalp was itchy and her hair felt greasy. Resident #44 further stated she would "love to have a shower at least once a week if they couldn't do it twice as scheduled". She was able to state her showers were scheduled in the evening on Tuesday and Friday,

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but no staff came to retrieve her. When asked how she kept herself clean she stated, "I use those wipes to wash my body and wipe my hair with them".

Resident #44 was interviewed again on 2/17/22 at 9:50 AM. She was sitting on her bedside playing a game on her phone. She explained she was scheduled for a shower on Tuesday of this week, but no one came to ask her or retrieve her for one. Resident #44 added she had not refused any showers and really wanted her hair washed due to being itchy.

On 2/17/22 at 10:10 AM, NA #2 was interviewed. She worked the 7:00 AM to 3:00 PM shift and was familiar with Resident #44, stating she was very independent. NA #2 was aware Resident #44 was scheduled for showers in the evening and was unaware of any refusals for personal care assistance.

An interview occurred with NA #7 on 2/17/22 at 3:55 PM. She worked the 3:00 PM to 11:00 PM shift and was most often assigned to care for Resident #44 when she worked. NA #7 stated Resident #44 "did her own thing" but could not recall her refusing showers. When reviewing the facility shower sheet for 2/1/22 and 2/15/22 she stated Resident #44 must have refused a shower that evening but failed to document what type of bath was provided. She was unable to answer how Resident #44's hair was washed.

On 2/17/22 at 5:33 PM, an interview was held with the Director of Nursing (DON) who had been employed at the facility since January 2022. She felt the lack of accountability could be to blame for not providing showers and shampoos as

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scheduled. The DON added she expected showers and shampoos to be provided/offered on the scheduled shower days.
3. Resident #1 was admitted to the facility on 1/25/21 with multiple diagnoses including bilateral above the knee amputation (AKA). The admission Minimum Data Set (MDS) assessment dated 2/1/21 indicated that it was somewhat important for Resident #1 to choose between tub bath, showers, bed bath or sponge bath. The quarterly MDS assessment dated 11/3/21 indicated that Resident #1's cognition was intact, and she did not have behaviors of rejection of care.

Resident #1's care plan dated 11/3/21 was reviewed. The care plan problem was "I have an activity of daily living (ADL) self-care performance deficit related to activity intolerance and bilateral AKA. The approaches included "to offer me choices in my daily care."

Review of the facility's shower scheduled revealed that Resident #1 was scheduled to have a shower twice a week every Monday and Thursday on day shift.

Review of the shower documentation for the last 4 months (October 21 to present) revealed that Resident #1 did not receive any shower, only bed bath.

Resident #1 was interviewed on 2/14/22 at 9:50 AM, She stated that she had not had a shower since she was admitted to the facility. Resident #1 reported that the staff had told her that she could not get in the shower since she didn't have legs. She added that she would prefer to have a shower, when she was at home, she used to

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F 561	Continued From page 25 have a shower every day. Resident #1 stated that her hair was only washed when the beautician was in the building and the beautician had not been coming due to the COVID outbreak. Nurse Aide (NA) #13, assigned to Resident #1, was interviewed on 2/16/22 at 1:40 PM. The NA stated that she was an agency staff, and she did not work at the facility often. She added that she did not know the scheduled shower days for Resident #1, but she had her hair done in the beauty shop this morning. NA #1, assigned to Resident #1, was interviewed on 2/17/22 at 9:30 AM. She stated that Resident #1 had refused showers, but she did not know if she had documented the refusal or not. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that she expected the staff to provide the shower as scheduled and to document if the resident had refused. The DON indicated that due to the turn- over in administrative staff, there was no oversight or monitoring to ensure that showers were provided. She added that the facility had agency staff and it was hard to hold them accountable.	F 561		
F 565 SS=D	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	F 565		3/29/22

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F 565	Continued From page 26 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 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 resident and staff interviews and record review, the facility failed to communicate the facility ' s efforts to address group concerns voiced in the Resident Council (RC) meetings and to resolve repeat concerns for 2 of 2 months of resident council meeting minutes reviewed. The findings included: Review of the RC meeting minutes dated	F 565	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	

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F 565	Continued From page 27 12/16/21 indicated several concerns related to nursing. A RC communication form was completed for the resident concerns and verbal follow up was provided to each resident individually. A RC communication form dated 12/16/21 included a concern voiced by Resident #3. Her quarterly Minimum Data Set (MDS) dated 11/6/21 indicated she was cognitively intact. Review of the RC meeting minutes dated 1/20/22 indicated several concerns related to nursing and Administration. A RC communication form was completed for administration regarding no improvements in concerns raised by the RC committee. RC communication forms dated 1/20/22 included a concerns voiced by Resident #3 and Resident #4. His quarterly MDS dated 11/10/21 indicated he was cognitively intact. A RC meeting was conducted on 2/15/22 at 9:30 AM. There were 2 alert and oriented participants, the RC president (Resident #3) and another resident (Resident #4) who routinely attended the meetings. Both residents voiced frustration with the facility for not addressing concerns/grievance discussed during the RC meetings. They stated this was a recent development since the previous Activity Director (AD) resigned in November 2021. Both reported the new AD started the first part of December 2021. An interview was conducted on 2/16/22 at 9:15 AM with the AD. She stated she started as the AD on 12/2/21. She further stated she did not review the December 16, 2021, RC meeting concerns during the 1/20/22 RC meeting. She validated the residents reported no improvements to the concerns reported during the 1/20/22 meeting.	F 565	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F565 The facility failed to communicate the facility ' s efforts to address group concerns voiced in the Resident Council (RC) meetings. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident Council meeting was held on 2/24/2022. Minutes were taken by the Activities Director. Concerns from the previous RC meeting on 1/20/22 were addressed and residents noted that there had been improvements in response to their grievances/concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning February 24, 2022 the prior month’s grievances/concerns will be reviewed after review of resident rights, information on how to make a grievance/concerns and survey information, and ambassador information. Current grievances/concerns as well as ongoing grievances/concerns from the previous month will be completed directly after the meeting by the Activities Director. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/25/2022, the Administrator educated the facility department heads on the following: • F565 requirements	

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F 565	Continued From page 28 An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting. He stated a concern or grievance should be addressed promptly with follow up provided to the members of the RC committee.	F 565	• The Administrator educated department heads on the grievance process and at the daily standup meeting on 2/25/22 assigned responsibility for resolving grievances. • Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances the morning after the RC meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor compliance utilizing the F565 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The tool will monitor to ensure that grievances from resident council meetings are addressed following the grievance process and are in compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the	

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F 565	Continued From page 29	F 565	weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		3/29/22

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F 604	Continued From page 30 restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Medical Director (MD) interviews and record review, the facility failed to identify an abdominal binder (a wide compression belt that encircles the abdomen) as a physical restraint. This was for 1 (Resident #42) of 1 residents reviewed for restraints. The findings included: Resident #42 was admitted on 11/25/15 with anoxic brain damage and dysphagia. Review of Resident #42's quarterly Minimum Data Set (MDS) dated 1/31/22 indicated severe cognitive impairment. The MDS was not coded for the use of a restraint. Review of Resident #42's comprehensive care plan last revised on 7/27/21 did not include a care plan for the use of his abdominal binder as a restraint. Review of a nursing note dated 10/28/21 at 4:52 AM read in part as follows: Increased calling out with restlessness and pulling at bed clothes. Abdominal binder in place for feeding tube protection because he attempts to grab and pull on his feeding tube. Review of Resident #42's February 2022 Physician orders included an order dated 2/15/22 for an abdominal binder over his feeding tube site to prevent removal. Review of Resident #42's electronic medical record (EMR) did not revealed documented evidence of a consent for the use of a restraint,	F 604	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F604 The facility failed to identify an abdominal binder as a physical restraint. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #42, on 02/16/2022 the Director of Nurses conferred with the physician and the abdominal binder was discontinued. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 03/04/2022 the Director of Nurses and Nurse Manager audited all current residents for the presence of any restraint devices with none identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/09/2022 Director of Nurses, Nurse Consultant and the Nurse Manager began education of all full time, part time, PRN	

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F 604	Continued From page 31 restraint assessment or reassessments and no evidence of an attempted restraint reduction or elimination. An interview was conducted on 2/16/22 at 8:30 AM with Nurse #3. She stated Resident #42 had an abdominal binder to prevent him for sucking on the feeding tube. She stated the binder had been in use for at least a year or more. An interview was conducted on 2/16/22 at 8:40 AM with Nursing Assistant (NA) #10. She stated she had never observed Resident #42 attempt to remove his abdominal binder and he probably would not be able to remove it. She stated she only opened the binder during his bath but all other times, it was secured in place with Velcro. An interview was conducted on 2/16/22 at 8:45 AM with NA #1. She stated she had never observed Resident #42 attempt to remove the abdominal binder. An interview was conducted on 2/16/22 at 10:22 AM with the Director of Nursing (DON). She stated it was decided to do away with Resident #42' abdominal binder and they were going to get him high waisted pants. The DON confirmed there was no documentation of a restraint consent, restraint assessment or reassessment and no documented attempts to try other less restrictive devices or an attempted elimination. An interview was conducted on 2/16/22 at 10:29 AM with the Nurse Consultant. She stated she told the staff to write the order yesterday for the use of the abdominal binder but now the facility opted to try high wasted pants to eliminate the binder.	F 604	and agency Nurses and CNA's on the following: • What is a physical restraint and types • Risks/Benefits of physical restraints • Releasing restraints • Physical restraint process • Restraint reduction process This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F604 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor restraints and the restraint process compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing	

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F 604	Continued From page 32 An observation was conducted on 2/16/22 at 11:10 AM with Nurse #3. She lifted Resident #42's shirt. There was observed a tan colored abdominal binder approximately 10-12 inches, included in width that extended around his abdomen and secured with Velcro. Nurse #3 asked Resident #42 to attempt to remove the abdominal binder. After several prompts to attempt to remove the abdominal binder, it was evident that Resident #42 could not follow commands and made no visible effort to touch the binder. Nurse #3 stated she thought he had removed it before but she was unable to say how long ago. She stated she had not be releasing the binder every few hours. An observation of Resident #42 was conducted on 2/17/22 at 10:29 AM. He was lying in bed on his left side wearing a shirt and a brief. He was not wearing any pants. He was not wearing his abdominal binder. Resident #42 was not observed touching the feeding tube but was noted pulling at his brief. Another review of Resident #42's Physician orders on 2/17/22 revealed the order dated 2/15/22 for the use of the abdominal binder was still an active order. An telephone interview was conducted on 2/17/22 at 4:56 PM with the MD. He stated Resident #42 needed the abdominal binder to prevent him from removing his feeding tube. The MD stated he understood the intent of the regulation. He stated it felt like a "catch 22" because no facility wanted to utilize a restraint but Resident #42's binder was medically necessary and should be considered a restraint.	F 604	program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 604	Continued From page 33 An interview was conducted on 2/17/22 at 6:00 PM with the DON. She stated Resident #42's abdominal binder was medically necessary but acknowledged it should be treated as a restraint since it restricts his access to his abdomen and he was unable to remove the binder.	F 604		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		3/29/22

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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F 623	Continued From page 35 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview with the responsible party (RP), and or resident and staff, the facility failed to notify the RP in writing of the reason for the discharge to the hospital for 4 of 5 sampled residents reviewed for hospitalizations (Residents #23, #5, 17 & #206). Findings included: 1. Resident #23 was admitted to the facility on 7/13/17.	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 623	Continued From page 36 Review of the nurse's note dated 10/25/21 at 11:38 AM revealed that the resident was discharged to the hospital after the resident was noted to be difficult to arouse and was readmitted back to the facility on 11/2/21. The nurse's note dated 11/11/21 at 12:02 AM revealed that Resident #23 was observed with a change in condition. The physician was notified, and the resident was sent to the hospital for evaluation. The resident was readmitted back to the facility on 11/15/2. The quarterly Minimum Data Set (MDS) assessment dated 12/31/21 indicated that Resident #23 had severe cognitive impairment. Nurse #3 was interviewed on 2/16/22 at 2:48 PM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. The Registered Nurse (RN) Supervisor was interviewed on 2/16/22 at 2:49 PM. The RN Supervisor stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Resident #23's Responsible Party (RP) was interviewed on 2/16/22 at 4;30 PM. The RP stated that Resident #23 was discharged and was admitted to the hospital in October and November 2021. The RP indicated that he/she had not received a letter from the facility informing him/her of the reason the resident was	F 623	F623 The facility failed to notify the responsible party in writing of the reason for hospital discharge. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/9/2022 the responsible parties of residents #23, 5, 17 and 206 were mailed written notice of the reason for discharge to the hospital by the Director of Nurses. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Any resident who is transferred or discharged has the potential to be affected. On 3/09/2022 the Director of Nurses audited all discharges for the last 7 days to monitor that the responsible party had been notified in writing of the reason for discharge to the hospital with no other discharges to hospital found. The Business Office Manager or Admissions Coordinator will assure that written notice is sent to the responsible party beginning on 3/16/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/09/22, the Director of Nurses and Nurse Consultant began education of all full time, part time and as needed nurses, social worker, administrator, admissions, business and office manager on facility	

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F 623	Continued From page 37 discharged to the hospital. The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. The DON stated that she didn't know the regulation to notify the RP in writing the reason for hospitalization. She reported that the nurse notified the RP by calling her/him. 2. Resident #5 was admitted to the facility on 5/12/21. Review of the nurse's note dated 9/16/21 at 3:15 PM revealed that the resident was discharged to the hospital due to complaint of severe pain and was readmitted back to the facility on 9/17/21. The quarterly Minimum Data Set (MDS) assessment dated 11/8/21 indicated that Resident #5's cognition was intact. Nurse #3 was interviewed on 2/16/22 at 2:48 PM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. The Registered Nurse (RN) Supervisor was interviewed on 2/16/22 at 2:49 PM. The RN Supervisor stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Resident #5 was interviewed on 2/16/22 at 3:10 PM. The resident verified that she was admitted	F 623	policy on notifying the responsible party in writing of the reason for a resident's discharge to the hospital. Education will be completed by 3/28/22 at which time all of the above must be in-serviced prior to working. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or Designee will monitor compliance utilizing the Written Notification of RP Hospital Discharge Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor for compliance with written notification of reason for a resident's discharge to the hospital. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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to the hospital months ago (unable to remember the exact date) and she had not received any letter from the facility about that discharge.

The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. The DON stated that she didn't know the regulation to notify the RP in writing the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.

3) Resident #17 was originally admitted to the facility on 3/1/21.

The quarterly Minimum Data Set (MDS) assessment dated 12/11/21, indicated Resident #17 was cognitively intact.

Resident #17's medical record revealed she was transferred to the hospital on 1/18/22 and was readmitted to the facility on 1/28/22. There was no documentation that a written reason for hospital transfer was provided to the resident and/or responsible party (RP).

On 2/16/22 at 2:48 PM, an interview occurred with Nurse #3, who stated she sent a copy of the face sheet, any Do Not Resuscitate (DNR) information if present, physician orders, medication and treatment administration records and the Bed Hold policy when a resident was transferred to the hospital. She called the RP by phone to notify them of the change and reason for hospital transfer.

The Registered Nurse (RN) Supervisor was interviewed on 2/16/22 at 2:49 PM and stated the nursing staff would call the RP in regard to the reason of the hospital transfer but was unaware of anything sent in writing.

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A phone interview was completed with Resident #17's RP on 2/16/22 at 5:00 PM. She stated the facility called when the hospital transfer occurred, but she had not received anything in writing.

The Administrator was interviewed on 2/17/22 at 10:01 AM and verified he was aware of the regulation regarding the need for written reason for hospital transfer to be sent to the resident and/or RP but it was not being done at the facility. He was unable to offer a reason.
4. Resident #206 was admitted 7/12/21.

Resident #206's quarterly Minimum Data Set dated 10/29/21 indicated he had severe cognitive impairment.

Review of a nursing note dated 12/10/21 at 1:23 PM read Resident #206 was sent to the hospital for an evaluation. The note read his responsible party (RP) was notified of his hospital transfer. There was no documentation that a written reason for hospital transfer was provided to the RP.

An interview was conducted on 2/16/22 at 2:48 PM with Nurse #3. She stated she sent a copy of the face sheet, any Do Not Resuscitate (DNR) information if present, physician orders, medication and treatment administration records and the Bed Hold policy when a resident was transferred to the hospital. She called the RP by phone to notify them of the change and reason for hospital transfer.

An interview was conducted on 2/16/22 at 2:49 PM with the Registered Nurse (RN) Supervisor. She stated the nursing staff would call the RP in

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F 623	Continued From page 40 regard to the reason of the hospital transfer but was unaware of anything sent in writing. A telephone call was made on 2/16/22 at 4:15 PM to Resident #206's RP. The cell mailbox was full but a message was left at home phone number to return surveyor's call. At the time of exit on 2/17/22 there was no return call from the RP. An interview was conducted with the Administrator on 2/17/22 at 10:01 AM. He verified he was aware of the regulation regarding the need for written reason for hospital transfer to be sent to the resident and/or RP but it was not being done at the facility. He was unable to offer a reason.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the required Significant Change in Status Assessment (SCSA) following her admission to hospice care for 1 of 1 sampled	F 637	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	3/7/22

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F 637	Continued From page 41 resident reviewed for hospice (Resident #23). Findings included: Resident #23 was admitted to the facility on 7/13/17 with diagnoses that included vascular dementia and delusional disorder. A physician's order dated 11/23/21 indicated a hospice evaluation was requested for Resident #23. A review of hospice documentation indicated Resident #23 was admitted to hospice care on 11/24/21. A review of Resident #23's Minimum Data Set (MDS) assessments indicated a SCSA had not been completed within 14 days of her admission to hospice care (12/7/21). The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She confirmed that Resident #23 was admitted to hospice services on 11/24/21. She reported that she was new to MDS at that time, and she did not know that a SCSA was required. An interview was conducted with the Director of Nursing on 2/27/21 at 3:34 PM. She indicated she expected the MDS to be completed accurately and as required.	F 637	compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 637 COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE Corrective Action: Resident #23 Resident elected Hospice benefits on 11/24/2021 and revoked hospice benefits on 2/12/2022 Identification of other residents who may be involved with this practice: All current residents who have elected or revoked Hospice Benefits have the potential to be affected by the alleged practice. On 3/3/2022 through 3/4/2022 an audit was completed by the MDS Nurse consultant to ensure that the facility had completed Significant Change in Status Comprehensive Minimum Data Set (MDS) assessments within 14days after the Assessment Reference Date (ARD) for residents who had elected or revoked hospice benefits. Out of the 55 current residents, 0 number of residents did not have their significant comprehensive assessments completed within 14 calendar days of electing or revoking hospice benefits. 4 current residents with hospice benefits have significant change assessments completed and 1 current resident has revoked hospice benefits and has a significant change assessment	

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F 637	Continued From page 42	F 637	completed. This audits were completed by 3/4/2022. Systemic Changes: On 3/4/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse Consultant. The education focused on: The education focused on: The facility must ; Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change “means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) If a resident elects the hospice benefit, the facility is required to complete an MDS Significant Change in Status Assessment (SCSA). The facility is required to complete an SCSA when they resident comes off the hospice benefit (revoke). The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity. OBRA-required comprehensive assessments include the completion of	

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F 637	Continued From page 43	F 637	both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident's first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates. Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life	

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F 637	Continued From page 44	F 637	history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns. (vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non licensed direct care staff members on all shifts. This in service was completed by 3/4/2022. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 637	Continued From page 45	F 637	Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records who have elected or revoked hospice benefits or with either two or more areas of decline or two or more areas of improvement ;this may include two changes within a particular domain (e.g., two areas of ADL decline or improvement) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks to ensure that a Significant Change in Status Assessment are completed timely.This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	
F 641 SS=E	Accuracy of Assessments	F 641		3/9/22

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F 641	Continued From page 46 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 reviews, observations, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of nutrition (Residents #12 and #52), restraints (Resident #42), dental status (Resident #42), accidents (Resident #16), pressure ulcers (Residents #14, #23 and #46) and pain management (Resident #46). This was for 7 of 22 residents reviewed. The findings included: 1) Resident #12 was admitted to the facility on 1/11/13 with diagnoses that included congestive heart failure (CHF), diabetes type 2 and morbid obesity. Resident #12's weight data revealed the following weights during the MDS assessment look back period of July 2021 to December 2021, which showed a 2.01% weight loss in a month and 24.19% weight loss in 6 months: 1/17/22- 159.6 pounds (lbs.) 12/22/21- 162.8 lbs. 7/7/21- 198.2 lbs. A quarterly MDS assessment dated 1/28/22 indicated Resident #12 was cognitively intact. She was coded with no weight loss or gains of 5% or more in the last month or 10% or more in the last 6 months.	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 12: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [1/28/2022] was modified. Resident #52: Resident Minimum Data Set (MDS) assessments (Annual Assessment,) with Assessment /Reference Date (ARD) [1/13/2021 and Resident Minimum Data Set (MDS) assessment (5 day PPS Assessment,) with Assessment /Reference Date (ARD) [1/25/2022] were modified. Resident #42: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [1/31/2022] was	

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F 641	Continued From page 47 On 2/17/22 at 2:55 PM, the Dietary Manager was interviewed and confirmed she coded the nutrition section on the MDS assessments. She reviewed the MDS assessment dated 1/28/22 as well as the weight data for Resident #12. The Dietary Manager stated she reviewed Resident #12's weights in the Electronic Medical Record prior to completing the MDS assessment and was able to view the weight dated 1/17/22 when she coded the 1/28/22 MDS assessment. The Dietary Manager indicated the assessment should have been coded for weight loss and stated it was oversight. During an interview with the Director of Nursing on 2/17/22 at 5:33 PM, she indicated it was her expectation for the MDS assessment to be coded accurately. 2a. Resident # 52 was admitted on 1/6/21 with cumulative diagnoses of breast cancer and Alzheimer's Disease. Review of Resident #52's weights revealed on 7/7/21 she weighed 183.6 pounds, and on 11/5/21 she weighed 164.8 pounds with a 11.76% weight loss over the past 5 months. There were no weights documented for December 2021. Resident #52's annual Minimum Data Set (MDS) dated 1/13/22 indicated she was not coded for any weight loss. An interview was conducted on 2/15/22 at 12:20 PM with the Dietary Manager (DM). The DM stated she did not code the annual MDS dated 1/13/22 correctly for Resident #52's documented weight loss.	F 641	modified. Abdominal binder discontinued 2/16/2022. Resident #16 Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [12/9/2021] was modified Resident #14: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [12/6/2021] was modified. Resident #23: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [12/31/2021] was modified. Resident #46: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) [1/17/2021] was modified. Identification of other residents who may be involved with this practice: All current residents who have weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months from assessment reference date(s); Who have Physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) during the Mini Data Set (MDS) 7 day look back for assessment reference date(s); who received scheduled pain medication regimen At any time during the Mini Data Set (MDS) 5 day look for	

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F 641	Continued From page 48 An interview was conducted on 2/17/22 at 6:00 PM with the Director of Nursing (DON). She stated Resident #52's MDS dated 1/13/22 should have been coded accurately to reflect her significant weight loss. 2b. Resident # 52 was admitted on 1/6/21 with cumulative diagnoses of breast cancer and Alzheimer's Disease. Review of Resident #52's weights revealed on 7/7/21 she weighed 183.6 pounds, and on 1/17/22 she weighed 163 pounds with a weight loss of 11.22% weight loss over the past 6 months. Resident #52's 5-Day Minimum Data Set (MDS) dated 1/25/22 indicated she was not coded for any weight loss. An interview was conducted on 2/15/22 at 12:20 PM with the Dietary Manager (DM). The DM stated she did not code the 5-day MDS dated 1/25/22 correctly for Resident #52's documented weight loss. An interview was conducted on 2/17/22 at 6:00 PM with the Director of Nursing (DON). She stated Resident #52's MDS dated 1/25/22 should have been coded accurately to reflect her significant weight loss. 3. Resident #42 was admitted on 11/25/15 with anoxic brain damage and dysphagia Review of Resident #42's quarterly Minimum	F 641	assessment reference date (s); Who have had a fall (s) since admission or prior assessment with no injury, with injury and with major injury from assessment reference date(s); Who has one or more unhealed pressure ulcers/injuries in the 7-day look back period of the Mini Data Set (MDS) for assessment reference date (s); who has surgical wound in the 7-day look back period of the Mini Data Set (MDS) for assessment reference date have the potential to be affected by the alleged practice. On 3/4/2022 through 3/7/2022 an audit was completed by the MDS Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months from assessment reference date(s) were coded accurately. 8 out of 54 residents were noted to have had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months from assessment reference date(s). 4 Resident Mini Date Set assessments were modified and 4 Mini Data Set assessments were already coded accurately. On 3/4/2022 through 3/7/2022 an audit was completed by the MDS Nurse Consultant to review Minimum Data Set (MDS) assessments to ensure that all current residents who have Physical restraints (any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot	

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F 641	Continued From page 49 Data Set (MDS) dated 1/31/22 indicated severe cognitive impairment. The MDS was not coded for the use of a restraint. An interview was conducted on 2/16/22 at 8:30 AM with Nurse #3. She stated Resident #42 had an abdominal binder to prevent him for sucking on the feeding tube. She stated the binder had been in use for at least a year or more. An interview was conducted on 2/16/22 at 8:40 AM with Nursing Assistant (NA) #10. She stated she had never observed Resident #42 attempt to remove his abdominal binder and he probably would not be able to remove it. She stated she only opened the binder during his bath but all other times, it was secured with Velcro. An observation of Resident #42 was conducted on 2/16/22 at 11:10 AM with Nurse #3. The nurse lifted his shirt, and a tan colored abdominal binder was observed extending around his abdomen and secured with Velcro. Nurse #3 asked Resident #42 to attempt to remove the abdominal binder. After several prompts, it was evident that Resident #42 could not follow commands and made no visible effort to touch the binder. An interview was conducted on 2/16/22 at 2:30 PM with the Minimum Data Set (MDS) Nurse. She stated she did not code Resident #42' abdominal binder as a restraint. She stated the abdominal binder was used to prevent Resident #42 from pulling out his feeding tube. The MDS Nurse stated she was not aware that the abdominal binder was a physical restraint if Resident #42 could not remove it. An interview was conducted on 2/17/22 at 6:00	F 641	remove easily which restricts freedom of movement or normal access to one's body) during the Mini Data Set (MDS) 7 day look back for assessment reference date(s) is coded accurately. All assessments coded accurately for physical restraints. Out of the 54 current residents in the facility, 0 have physical restraints. On 3/4/2022 through 3/7/2022 an audit was completed by the MDS Nurse Consultant to review Minimum Data Set (MDS) assessments to ensure that all current residents who received scheduled pain medication regimen At any time during the Mini Data Set (MDS) 5 day look for assessment reference date (s) is coded accurately. All assessments coded accurately for scheduled pain management. On 3/4/2022 through 3/7/2022 an audit was completed by the MDS Nurse to review Minimum Data Set (MDS) assessments to ensure that all current residents who have had a fall (s) since admission or prior assessment with no injury, with injury and with major injury from assessment reference date(s) is coded accurately. All assessments coded accurately for falls. On 3/4/2022 through 3/7/2022 an audit was completed by the MDS Nurse Consultant to review Minimum Data Set (MDS) assessments to ensure that all current residents who have surgical wounds and/or unhealed pressure ulcers in the 7 day look back of the Mini Data Set is coded accurately All assessments coded accurately. All assessments coded	

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F 641	Continued From page 50 PM with the Director of Nursing (DON). She stated the facility did not consider the abdominal binder as a physical restraint, but she expected it to be coded accurately since he was unable to remove it. 4 a. Resident #46 was admitted to the facility on 1/10/22. The facility's weekly pressure ulcer review form dated 1/12/22 was reviewed. The form revealed that Resident #46 had 1 unstageable pressure ulcer on her right iliac crest measuring 4 centimeter (cm) by 2 cm. The admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated that Resident #46 had 1 unstageable pressure ulcer that was present on admission. Review of the care area assessment (CAAs) and the care plan dated 1/17/22 revealed that Resident #46 had a pressure ulcer, unstageable to the right lower back. Review of the Wound Physician note dated 1/18/22 revealed a post-surgical wound on the right lower back. The note indicated that Resident #46 had undergone T11 (thoracic vertebra) - L4 (lumbar spine) spinal fusion and L4 vertebroplasty (a procedure for stabilizing compression fractures of the spine). "Today on examination, the open wound was overlying part of her incision". The Wound Nurse was interviewed on 2/15/22 at 1:32 PM. She stated that she started as Wound Nurse in October 2021. She made rounds with the Wound Physician weekly and transcribed the treatment plan as recommended. She reviewed	F 641	accurately for surgical wounds and/or unhealed pressure ulcers. This was completed on 3/7/2022. Systemic Changes: On 3/8/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident's status. Section K0300. Weight loss: Loss of 5% or more in the last month or loss of 10% or more in last 6 months. This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary. Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of	

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the Wound Physician note dated 1/18/22 and verified that the wound on the right lower back was a surgical wound and not a pressure ulcer.

The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She reported that she got the information from the Wound Nurse assessment and documentation in completing the MDS assessments for pressure ulcers and wounds. She stated that the Wound Nurse had assessed the wound on Resident #46 ' s right lower back as a pressure ulcer. She reviewed the Wound Physician note dated 1/18/22 and verified that the wound was a surgical wound and not a pressure ulcer. She stated that the admission MDS dated 1/17/22 was not accurate in the area of pressure ulcer. The resident has a surgical wound and not a pressure ulcer wound.

The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the MDS Nurse and the Wound Nurse were new to their position but that was not an excuse to make these errors. They were expected to be responsible and accountable.

4 b. Resident #46 was admitted to the facility on 1/10/22.

The admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated that Resident #46 was not on a scheduled pain medication.

Resident #46 had a doctor's order dated 1/10/22

fluid with physician orders for diuretics, K0300 can be coded as 1 Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Section J0100A. Received scheduled pain medication regimen. Determine all interventions for pain provided to the resident during the 5-day look-back period. Answer these items even if the resident currently denies pain Code 0, no: if the medical record does not contain documentation that a scheduled pain medication was received. Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received. Section J1900. Number of Falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS). Coding Instructions for J1900A, No Injury Code 0, none: if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Code 1, one: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Code 2, two or more: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Coding Instructions for J1900B, Injury (Except Major) Code 0, none: if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled

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for Lidocaine patch 5% (used to treat symptoms of nerve pain) - apply in AM and remove at HS for pain.

Review of the January 2022 Medication Administration Records (MARs) revealed that Resident #46 had received Lidoderm patch daily during the assessment period.

The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She reviewed the doctor's orders and MARs, and she verified that the admission MDS assessment dated 1/17/22 was coded wrong in the area of pain management. She reported that the resident was on scheduled pain medication.

The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the MDS Nurse was new to her position but that was not an excuse to make these errors. The DON stated that she expected the MDS assessments to be coded accurately.

5. Resident #16 was admitted to the facility on 6/2/21

The quarterly Minimum Data Set (MDS) assessment dated 12/9/21 indicated that Resident #16 had 2 or more falls with no injury since admission, reentry, or prior assessment.

The incident reports for Resident #16 were reviewed. The report dated 9/9/21 revealed that the resident had a fall and the x-ray report dated 9/10/21 revealed acute, non-displaced fracture at

PPS).Code 1, one: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). Code 2, two or more: if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Coding Instructions for J1900C, Major Injury Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). Code 2, two or more: if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Coding Tip: If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the assessment must be modified to update the level of injury that occurred with that fall. Section M0210 Unhealed Pressure Ulcers/Injuries. Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers.

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base of first distal phalanx and mild subluxation at first metacarpophalangeal joint.

The report dated 9/15/21 at 6:59 AM revealed that Resident #16 was observed sitting on the floor at the doorway of room. Resident was assessed for injury. Range of motion to all extremities with no change in limitations noted.

The nurse's note dated 9/15/21 at 9:41 AM revealed that Resident #16 noted to be in pain when trying to stand up. When asked, she stated that her hips hurt. The resident was medicated with Tramadol (a narcotic used to treat pain).

The nurse's note dated 9/23/21 revealed that Resident #16 continued not to bear weight on her right lower extremity, the physician was notified and computerized tomography CT) scan of the pelvis was ordered.

The CT scan report dated 9/24/21 revealed displaced comminuted right superior pubic ramus fracture and nondisplaced left inferior pubis ramus fracture.

The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. The MDS Nurse reported that she only reviewed the incident reports and not the nurse's notes when completing the MDS assessments for falls. She reviewed the nurse's notes and the x-ray/CT reports and verified that the quarterly MDS assessment dated 12/9/21 was coded wrong in the area of falls. Resident #16 had falls with major injury.

The Director of Nursing (DON) was interviewed

Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Section M: Other Ulcers, Wounds and Skin Problems. Review the medical record, including skin care flow sheets or other skin tracking forms. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. Examine the resident and determine whether any ulcers, wounds, or skin problems are present. Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot). if there is no evidence of such problems in the last 7 days, check none of the above. Surgical wounds Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites. Section P0100. Physical Restraints. Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
This in service was completed by

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F 641	Continued From page 54 on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the MDS Nurse was new to her position but that was not an excuse to make these errors. The DON stated that she expected the MDS assessments to be coded accurately. 6. Resident #14 was admitted to the facility on 9/4/17. The quarterly Minimum Data Set (MDS) assessment dated 12/6/21 indicated that Resident #14 had 1 stage 4 pressure ulcer that was present on admission. Review of the Wound Physician note dated 11/30/21 revealed that Resident #14 had 1 stage 4 pressure ulcer on the sacrum and 1 stage 3 pressure ulcer on the right buttock. Review of the December 2021 Treatment Administration Records (TARs) revealed that Resident #14 had received treatment to his sacral and right buttock pressure ulcers during the assessment period. The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She reviewed the Wound Physician notes and the TARs and verified that the quarterly MDS assessment dated 12/6/21 was coded wrong in the area of pressure ulcers. Resident #14 had stage 3 and stage 4 pressure ulcers. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022.	F 641	3/9/2022. Any The Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that section K0300. Weight loss: Loss of 5% or more in the last month or loss of 10% or more in last 6 months; Section J0100A. Received scheduled pain medication regimen; Section J1900. Number of Falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS); Section M0210 Unhealed Pressure Ulcers/Injuries; Section M: Other Ulcers, Wounds and Skin Problems; Section P0100. Physical Restraints are coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly	

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F 641	Continued From page 55 She stated that the MDS Nurse was new to her position but that was not an excuse to make these errors. The DON stated that she expected the MDS assessments to be coded accurately. 7. Resident #23 was admitted to the facility on 7/13/17. The quarterly Minimum Data Set (MDS) assessment dated 12/31/21 indicated that Resident #23 did not have a pressure ulcer. The Wound Physician note dated 12/28/21 indicated that Resident #23 had a stage 3 pressure ulcer on her left buttock and the treatment plan was Calcium Alginate (a highly absorbent that promotes healing). Review of the December 2021 Treatment Administration Records (TARs) revealed that Resident #23's left buttock pressure ulcer was treated with calcium alginate during the assessment period. The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She reviewed the Wound Physician notes and the TARs and verified that the quarterly MDS assessment dated 12/31/21 was coded wrong in the area of pressure ulcers. Resident #23 had a stage 3 pressure ulcer during the assessment period. The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the MDS Nurse was new	F 641	QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	

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F 641	Continued From page 56 to her position but that was not an excuse to make these errors. The DON stated that she expected the MDS assessments to be coded accurately.	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)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		3/9/22

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F 656	Continued From page 57 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, observations and staff interviews, the facility failed to implement care planned interventions after a fall (Resident #40) for 1 of 22 residents reviewed. The findings included: Resident #40 was admitted to the facility on 6/7/15 with diagnoses that include dementia and history of falling. A review of the active physician orders revealed an order dated 3/26/20 for a scoop mattress to help define borders. Review of Resident #40's medical record included a nursing progress note, written by Nurse #3, revealed she was found on the floor next to her bed on 11/26/21 at 4:54 PM. Resident #40 was unable to describe how she fell. Resident #40's active care plan, last reviewed 12/2/21, included a focus area for actual fall with risk for further falls. The interventions included scoop mattress to help define bed boundaries. An Interdisciplinary Departmental Team (IDT) meeting was held on 12/14/21 to review the fall	F 656	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F656 Develop/Implement Comprehensive Care Plan Corrective Action: Resident #40: Care plan reviewed and revised on 2/16/2022 by interdisciplinary team. Scoop mattress resolved, resident has new implementation to have fall mat at beside while in bed (both sides of bed) Identification of other residents who may be involved with this practice: All current residents with care plan interventions after a fall have the potential to be affected by the alleged practice. On 3/8/2022 through 3/9/2022 an audit was completed by the Director of Nursing and MDS Coordinators, to ensure that a care	

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F 656	Continued From page 58	F 656		

that occurred on 11/26/21. Nurse #1 indicated foam floor mats were on each side of the bed for safety. The note indicated the care plan was reviewed. The root cause of the fall was determined to be confusion.

A nursing progress note, dated 1/17/22, written by Nurse #2, revealed Resident #40 was observed laying on the floor on her back beside the bed at 12:11 PM.

An IDT meeting was held on 1/18/22 to review the fall that occurred on 1/17/22. Resident #40 was unable to explain what happened at the time of the fall. An intervention of offering assistance out of bed upon waking in the morning was suggested.

A quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and had one fall with no injury.

On 2/14/22 at 11:30 AM, Resident #40 was observed lying in bed with her eyes closed. There was no scoop mattress present, or foam fall mats to either side of the bed. Observation of the bathroom in Resident #40's room revealed a foam fall mat leaning against the wall.

Resident #40 was observed on 2/15/22 at 10:42 AM lying in bed without a scoop mattress or fall mats to either side of the bed. A foam fall mat was observed against the wall in the bathroom of Resident #40's room.

On 2/15/22 at 1:19 PM, Resident #40 was observed lying in bed with her eyes closed. There was no scoop mattress or fall mats present to

plan was implemented for current residents with careplan interventions after a fall to ensure that the interventions were implemented as indicated on the plan of care. All current residents with a care plan intervention after a fall, have interventions implemented as indicated on the plan of care. This was completed on 3/9/2022.
Systemic Changes:
On 3/9/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident's exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on the

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F 656	Continued From page 59 either side of the bed. An interview occurred with Nurse Aide (NA) #7 on 2/15/22 at 3:48 PM, who was familiar with Resident #40. She was unaware a scoop mattress should be in place or fall mats. Stated she monitored Resident #40 for safety by checking on her frequently. Resident #40 was observed on 2/16/22 at 10:22 AM, lying in bed with her eyes closed. A scoop mattress was not in place nor fall mats to any side of the bed. A fall mat was observed against the wall of Resident #40's bathroom. NA #4 was interviewed on 2/16/22 at 2:00 PM and stated she had been assisting the facility since November 2021 and worked both the first (7:00 AM to 3:00 PM) and second (3:00 PM to 11:00 PM) shifts. She was familiar with Resident #40 and was unaware a scoop mattress was to be in place or fall mats utilized to the side of her bed. On 2/16/22 at 3:29 PM, Nurse #1 was interviewed and verified she had reviewed Resident #40's fall that occurred on 11/26/21. She was unable to recall if the foam fall mats were an intervention due to that particular fall or was already in place. Furthermore, Nurse #1 was unable to explain why Resident #40 did not have fall foam mats in place or the scoop mattress. She indicated Resident #40 had a recent room change (1/25/22 to 2/9/22) and the devices might not have moved with her. The Registered Nurse (RN) supervisor was interviewed on 2/16/22 at 3:45 PM. She reviewed the care plan and active physician orders which stated a scoop mattress was present and the fall	F 656	residents goals for admission and desired outcomes, the resident's preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be reviewed and implemented for all residents after a fall . This in service was completed by 3/9/2022. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident's with a interventions for a falls careplan to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of	

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F 656	Continued From page 60 investigation dated 12/14/21 indicating foam fall mats were to present to each side of the bed. The RN supervisor indicated a fall mat was found in the bathroom of Resident #40 but was unable to explain why the devices were not in place. The Director of Nursing was interviewed on 2/17/22 at 5:33 PM, indicating she had just stated employment at the facility in January 2022. She stated it was her expectation for the safety interventions to be utilized and expected the nursing staff as well as the nursing supervisor to ensure they were in place.	F 656	Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		3/9/22

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F 657	Continued From page 61 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to review and revise the care plan in the areas of medication (Resident #17) and pressure ulcer (Resident #14). This was for 2 of 22 residents reviewed. The findings included: 1) Resident #17 was originally admitted to the facility on 3/1/21 and most recently readmitted on 1/28/22. Her diagnoses included diabetes type 2 and hypertension. The medical record for Resident #17 was reviewed and indicated Anastrozole (a medication used as a hormonal chemotherapy) 1 milligram (mg) by mouth once a day for breast cancer in women after menopause was discontinued on 7/27/21. Resident #17's active care plan, last reviewed 11/22/21, included a focus area "I am on hormonal chemotherapy related to previous breast cancer." A review of the January 2022 Medication Administration Record (MAR) revealed Resident #17 did not receive any type of hormonal chemotherapy medication. On 2/17/22 at 1:54 PM, an interview occurred with the MDS Nurse. After reviewing Resident	F 657	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 Care Plan Timing and Revision Corrective Action: Resident #17: Care plan for antineoplastic medication resolved on 2/17/2022 by MDS nurse. Resident #14: Care plan for pressure ulcers revised and updated on 3/9/2022 by MDS nurse. Identification of other residents who may be involved with this practice: All current residents receiving antineoplastic medication; all current residents with pressure ulcers have the potential to be affected by the alleged practice. On 3/7/2022 through 3/8/2022 an audit was completed by the Minimum Data Set (MDS) Nurse Consultant to ensure that a care plan was implemented	

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F 657	Continued From page 62 #17's care plan and medical record she confirmed the hormonal chemotherapy medication was discontinued on 7/27/21 and should have been resolved from the care plan when it was reviewed on 11/22/21. The Director of Nursing was interviewed on 2/17/22 at 5:33 PM and indicated it was her expectation for the care plan to be an accurate representation of the resident. 2. Resident #14 was admitted to the facility on 9/4/17 with multiple diagnoses including developmental disorder that affects communication and behavior. The quarterly Minimum Data Set (MDS) assessment dated 12/6/21 indicated that Resident #14 had moderate cognitive impairment and had 1 stage 4 pressure ulcer. Resident #14's care plan dated 12/6/21 indicated that the resident had pressure ulcers to his sacrum, right and left buttocks. The care plan was not revised as of 2/17/22 to address the pressure ulcers to the right thigh and the left heel. The Wound Physician note dated 12/10/21 indicated that Resident #14 had developed pressure ulcers on his right thigh (unstageable) and Left heel (unstageable). The December 2021 Treatment Administration Records (TARs) revealed that the ulcers were treated with skin prep and covered with foam dressing daily. The Wound Physician note dated 1/11/22 revealed that Resident #14 continued to have pressure ulcers to his right thigh (unstageable) and to his left heel (stage 3). The January 2022 TARs revealed that the right thigh was treated with Santyl (a debriding agent), and the left heel	F 657	for current residents on antineoplastic medication and on residents with pressure ulcers. 1 current resident is on antineoplastic medication and care plan is updated, and all current residents with pressure ulcers have updated care plans. This was completed on 3/8/2022. Systemic Changes: On 3/9/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop, implement, review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident's exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on the residents goals for admission and desired	

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F 657	Continued From page 63 was treated with calcium alginate daily. The Wound Physician note dated 2/8/22 revealed that resident #14 continued to have pressure ulcers to his right thigh (unstageable) and to his left heel (stage 3). The February 2022 TARs revealed that both ulcers were treated with calcium alginate daily. The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. The MDS Nurse stated that she started as MDS Nurse 4-5 months ago. She reviewed the Wound Physician notes and the TARs and verified that Resident #14 had pressure ulcers on the right thigh and left heel, and she should have added them on the care plan, but she missed it. The MDS Nurse stated that she would revise the care plan to address the ulcers on the right thigh and left heel. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the MDS Nurse was new to her position but that was not an excuse to make these errors. The DON stated that she expected the care plan to be reviewed and reviewed when indicated.	F 657	outcomes, the resident's preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must developed, implemented, reviewed and revised upon admission, readmission and with any change in condition. This in service was completed by 3/9/2022. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 residents who are receiving antineoplastic medication to ensure that care plan is reviewed /revised. The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident's with pressure ulcers to ensure that care plan is reviewed /revised. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator	

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F 657	Continued From page 64	F 657	for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide medicated shampoo as ordered (Resident #40) for 1 of 22 sampled residents reviewed. The findings included: Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment. She required extensive assistance with personal hygiene and bathing. A review of Resident #40's February 2022 physician orders revealed an order for	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 The facility failed to provide medicated shampoo to a resident as ordered. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/ 18/2022 the RN Supervisor verified that the medicated shampoo had been	3/29/22

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F 658	Continued From page 65 Ketoconazole Shampoo (an antifungal shampoo) 2% to be applied to the scalp topically every evening shift on Monday and Thursday for tinea versicolor (a common fungus). Use on the scalp and hair and rinse well on shower days. This order was initiated on 5/20/20. Resident #40's room history was reviewed and indicated she had been in the same room since 7/2/21 with a scheduled shower/shampoo on Tuesday and Friday during the day shift (7:00 AM to 3:00 PM). She had a short stay in a different room on the same hallway from 1/25/22 to 2/9/22 with the shower/shampoo scheduled on Wednesday and Saturday during the day shift. A review of the February 2022 Medication Administration Record (MAR) revealed the Ketoconazole shampoo was signed as provided to Resident #40 on Monday and Thursdays as ordered (2/3/22, 2/7/22 and 2/14/22). Nurse #1 was interviewed on 2/15/22 at 3:54 PM, who had signed the February 2022 MAR, that Resident #40 received Ketoconazole shampoo on 2/14/22. The nurse stated she had assumed it was done by the Nurse Aide (NA) because they didn't tell her it wasn't done. Nurse #1 added she had not verified the shampoo had been provided as ordered. On 2/16/22 at 8:30 AM, an interview occurred with Nurse #3. She had signed off on the February 2022 MAR that Resident #40 received Ketoconazole shampoo on 2/3/22 and 2/7/22. Nurse #3 stated she didn't verify with the NA that the shampoo had occurred but had assumed it had since the NA had not told her otherwise.	F 658	administered to resident # 40 as ordered by direct observation. On 3/11/2022 the medicated shampoo administration was reviewed by the nurse manager and is aligned to be administered on scheduled shower days. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/08/2022 the Director of Nurses and RN Supervisor audited all residents with orders for medicated shampoo and monitored to assure the resident was receiving the medicated shampoo as ordered. Results: 2 of 2 residents were in compliance as of 3/08/2022. On 3/11/2022 the nurse manager audited all other residents who receive medicate shampoo to assure administration is aligned with their shower schedule. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/09/2022 the Director of Nurses, Nurse Consultant and RN Supervisor began in-service education to all full time, part time, and as needed and agency nurses Topics included: • Following physician orders for treatments orders. • Confirming that treatment orders such as for medicated shampoo are being provided as ordered before signing the treatment out as completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be	

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NA #4 was interviewed on 2/16/22 at 2:00 PM and stated she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM (first) and 3:00 PM to 11:00 PM (second) shifts. NA #4 was familiar with Resident #40 and was often assigned to care for her when she worked. NA #4 was unaware Resident #40 required to be shampooed with Ketoconazole.

On 2/17/22 at 9:35 AM, NA #1 was interviewed and stated she worked both the first and second shifts and was often assigned to Resident #40 when she worked. NA #1 was unaware Resident #40 required Ketoconazole shampoo.

A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM. She indicated she worked with an agency, had been assisting the facility since December 2021 and worked both first and second shifts. NA #12 was assigned to Resident #40 on 2/14/22 second shift. She stated Resident #40 was scheduled for showers/shampoos on the first shift, so she had not provided one to her on 2/14/22. NA #12 added she was unaware Resident #40 was to be shampooed with Ketoconazole.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The DON felt the lack of follow through to ensure Resident #40 received her medicated shampoo was lack of accountability and expected all orders to be followed.

reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nursing and/or designee will utilize the QA tool for F 658 to monitor compliance with administration of treatment orders. The Director of Nurses and/or designee will monitor 2 residents with orders for medicated shampoo weekly for 2 weeks, then monthly for 3 months for compliance with the ordered treatment. This will include direct observation of 2 residents on scheduled days for administration of the medicate shampoo. (On various day and evening shifts and days of the week to include weekends if applicable). This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health

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F 658	Continued From page 67	F 658	Information Manager, Dietary Manager, Maintenance Director, Medical Director.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide nail care (Resident #29, Resident #31, Resident #52, Resident #54 and Resident #40) to residents dependent on staff assistance with activities of daily living (ADLs). This was for 5 of 8 reviewed for ADLs. The findings included: 1. Resident #29 was admitted on 7/6/17 with diagnoses of Cerebral Vascular Accident (CVA) and right sided hemiplegia. Resident #29's annual Minimum Data Set dated 1/5/22 indicated he had moderate cognitive impairment, exhibited no behaviors and was coded for limited staff assistance with his personal hygiene. Review of Resident #29's ADL Care Area Assessment (CAA) dated 1/5/22 read in part as follows: Resident #29 had a history of a CVA and right sided hemiplegia. He was alert, oriented and able to make his needs known most of the time. Resident #29 required extensive staff assistance with the completion of most of his ADLs. Review of Resident #29's comprehensive care	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 The facility failed to provide nail care. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #29, on 03/03/2022 nail care was provided and documented by the hall nurse. For resident #31, on 03/03/2022 nail care was provided and documented by the hall nurse. For resident # 52, on 03/03/2022 nail care was provided and documented by the hall nurse. For resident # 40, on 03/03/2022 nail care	3/29/22

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F 677	Continued From page 68 plan last revised on 1/21/22 read he had a ADL self-care deficit due to his right sided hemiplegia. He was care planned to specific behaviors but there was no evidence of a care plan for ADL refusals. An observation was conducted on 2/14/22 at 11:06 AM. Resident #29's fingernails on both hands extended past fingertips and under her nails, it appeared black to suggest a lack of cleaning. Resident #29 stated the staff has not assisted him with his nail care in a long time. He stated it was his preference not to take showers but only bed baths. An observation was conducted on 2/15/22 at 12:00 PM. There was no change in the appearance of his fingernails. An interview was conducted on 2/16/22 at 8:30 AM with Nurse #3. She stated the aides provide nail care for the nondiabetic residents and the nurses did the fingernails of the diabetic residents. An interview was conducted on 2/16/22 at 8:40 AM with Nursing Assistant (NA) #10. She stated she was an agency aide and had not worked at the facility very long. She stated she was instructed that the aides could provide nail care to any resident who was not a diabetic. The nurses were to provide nail care to all the diabetic residents. An interview was conducted on 2/16/22 at 8:45 AM with NA #1. She stated she had only been working at the facility for a month. She stated she did not cut any fingernails and she only cleaned the resident's nails with a nail brush.	F 677	was provided and documented by the hall nurse. For resident 54, on 3/03/2022 nail care was provided and documented by the hall nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. Beginning on 03/03/2022, the nurse manager began auditing all current residents for the need of nail care. This audit will be completed by 03/04/2022. Nail care was provided to those residents identified in need of nail care. The Minimum Data Set Nurse will then task the requested shower schedule to Point Click Care tasks to fire to the certified nursing assistant's for documentation. This will be completed by 03/08/2022 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/09/2022, the Director of Nurses, Nurse Consultant and RN Nurse Manager began education of all full time, part time, and PRN Nurses and CNA's on the following: • Nail care should be performed daily with baths/showers and documented by the CNA in tasks in PCC. • Refusal documentation for CNA's/Nurses. • Diabetic nail care schedule and documentation by nurses.	

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F 677	Continued From page 69 An observation was conducted on 2/16/22 at 9:30 AM. There was no change in the appearance of his fingernails. An interview was conducted on 2/17/22 at 12:20 PM with NA #5. She stated she had worked at the facility for a year and a half. She stated the aides were allowed to trim fingernails of any nondiabetic residents. NA #5 stated Resident #29 did not refuse any of his ADLs but since he did not take showers, his nail care was likely forgotten. She stated she would provide Resident #29 nail care before leaving for the day. An interview was conducted on 2/17/22 at 6:00 PM with the Director of Nursing (DON). She stated she started as the DON in January 2022. The DON stated she was aware there were problems with staff not performing needed ADLs and the facility had started a quality assurance and performance improvement (QAPI) to address the problem. She stated with the new outbreak of COVID, staff out with COVID and agency staff, it had been difficult complete the QAPI. 2. Resident #31 was admitted on 1/27/16 with cumulative diagnoses of Diabetes, Cerebral Vascular Accident (CVA) with left sided hemiplegia. Resident #31's quarterly Minimum Data Set (MDS) dated 1/30/22 indicated he was cognitively intact, exhibited no behaviors and coded for limited staff assistance with his personal hygiene. Review of Resident #31's comprehensive care plan last revised on 1/24/22 read he had a ADL	F 677	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. Auditing will include various shifts and days of the week to include weekends. The Director of Nursing will monitor nail care compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS	

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self-care deficit due to his left sided hemiplegia. Interventions included staff assistance with his personal hygiene. He was care planned for resisting care but no care plan for ADL refusals. refusals.

An observation was conducted on 2/14/22 at 11:55 AM of Resident #31. His fingernails on both hands extended past fingertips and under her nails, it appeared black to suggest a lack of cleaning. Resident #31 stated the staff has not assisted him with his nail care in a long time. He stated it was his preference not to take showers but only bed baths.

An observation was conducted on 2/15/22 at 9:30 AM. There was no change in the appearance of his fingernails.

An interview was conducted on 2/16/22 at 8:30 AM with Nurse #3. She stated the aides provide nail care for the nondiabetic residents and the nurses did the fingernails of the diabetic residents. She stated for the diabetic residents, it was scheduled weekly and appeared on their Treatment Administration Record (TAR) to initial off when completed.

An interview was conducted on 2/16/22 at 8:40 AM with Nursing Assistant (NA) #10. She stated she was an agency aide and had not worked at the facility very long. She stated she was instructed that the aides could provide nail care to any resident who was not a diabetic. The nurses were to provide nail care to all the diabetic residents.

An observation was conducted on 2/16/22 at 9:10 AM. There was no change in the appearance of

Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

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his fingernails.

A review of Resident #31's TAR for February 2022 indicated Nurse #3 performed Resident #31's nail care on 2/16/22.

An observation was conducted on 2/17/22 at 4:00 PM. There was no change in the appearance of his fingernails.

An interview was conducted on 2/17/22 at 4:10 PM with Nurse #3. She confirmed she signed off on Resident #31's diabetic nail care yesterday. Nurse #3 stated she must have signed off that she had performed his nail care and on her way to do it when she got pulled away and didn't go back to do it. She stated she would complete his nail care prior to her leaving at 7:00 PM.

An interview was conducted on 2/17/22 at 6:00 PM with the Director of Nursing (DON). She stated she started as the DON in January 2022. The DON stated she was aware there were problems ADLs and the facility had started a quality assurance and performance improvement (QAPI) to address the problem. She stated with the new outbreak of COVID, staff out with COVID and agency staff, it had been difficult to complete the QAPI.

3. Resident # 52 was admitted on 1/6/21 with cumulative diagnoses of Alzheimer's Disease and Diabetes.

Review of Resident #52's ADL care plan last revised on 5/6/21 for an ADL self-care performance deficit due to her activity intolerance and dementia. There was no intervention listed to

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address her personal hygiene.

Resident #52's 5-day Minimum Data Set (MDS) dated 1/25/22 indicated severe cognitive impairment, no behaviors and coded for limited assistance with personal hygiene.

An observation was conducted on 2/14/22 at 12:30 PM. Resident #52's's fingernails on both hands extended past fingertips and under her nails, it appeared black to suggest a lack of cleaning.

An observation was conducted on 2/15/22 at 12:10 PM. There was no change in the appearance of her fingernails.

An interview was conducted on 2/16/22 at 8:30 AM with Nurse #3. She stated the aides provide nail care for the nondiabetic residents and the nurses did the fingernails of the diabetic residents. She stated for the diabetic residents, it was scheduled weekly and appeared on their Treatment Administration Record (TAR) to initial off when completed.

A review of Resident #52's TAR for February 2022 did not include nail care scheduled weekly to be initialed off when completed.

An interview was conducted on 2/16/22 at 8:40 AM with Nursing Assistant (NA) #10. She stated she was an agency aide and had not worked at the facility very long. She stated she was instructed that the aides could provide nail care to any resident who was not a diabetic. The nurses were to provide nail care to all the diabetic residents.

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An observation was conducted on 2/16/22 at 12:25 PM. There was no change in the appearance of her fingernails.

An observation was conducted on 2/17/22 at 4:02 PM. There was no change in the appearance of her fingernails.

An interview was conducted on 2/17/22 at 4:10 PM with Nurse #3. She stated her nail care did not appear on her TAR so she figured Resident #52 wasn't a diabetic. Nurse #3 was reminded that Resident #52 received insulin prior to her breakfast. She stated it was an oversight and she would complete her nail care prior to her leaving at 7:00 PM.

An interview was conducted on 2/17/22 at 6:00 PM with the Director of Nursing (DON). She stated she started as the DON in January 2022. The DON stated she was aware there were problems ADLs and the facility had started a quality assurance and performance improvement (QAPI) to address the problem. She stated with the new outbreak of COVID, staff out with COVID and agency staff, it had been difficult complete the QAPI.

4a) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia, macular degeneration, and osteoarthritis.

Resident #40's active care plan, last reviewed on 12/2/21, included the following focus areas:
- Activities of Daily Living (ADL) self-performance deficit. The interventions included staff assistance with grooming and personal hygiene
- History of smearing feces and required frequent rounding and monitoring for incontinence.

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The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and required extensive assistance with personal hygiene and bathing.

A review of the nursing progress notes from 9/1/21 to 2/16/22 revealed no refusals specific to nail care documented.

An observation was made of Resident #40 on 2/14/22 at 11:30 AM while she was lying in bed with hands laying on top of the covers. She was noted to have a dark substance under the third and fourth fingernails to the right hand.

On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in bed eating lunch with her fingers. The dark substance to the third and fourth right hand fingernails remained.

A phone interview was completed with a family member of Resident #40 on 2/14/22 at 2:31 PM, who explained Resident #40 had a history of smearing feces on herself and the bed and wondered if she was having nail care completed regularly.

Resident #40 was observed on 2/15/22 at 10:42 AM sitting up in her bed. A dark substance remained to the third and fourth fingernails of the right hand.

On 2/15/22 at 12:15 PM, Resident #40 was observed to be eating lunch using her right-hand fingers.

Another observation of Resident #40 occurred on 2/15/22 at 1:19 PM where the dark substance

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was still visible under the third and fourth right hand fingernails.

Nurse #1 was interviewed on 2/15/22 at 3:54 PM and explained nail care was completed by the Nurse Aides (NAs) during personal care.

On 2/16/22 at 8:30 AM, NA #1 was interviewed and explained the only nail care she completed was with the nail brush when needed during personal care. She could neither confirm nor deny providing recent nail care to Resident #40.

Nurse #2 was interviewed on 2/16/22 at 11:02 AM and explained NAs provided nail care during personal care ensuring the nails were clean and free of jagged edges. Nurse #2 observed Resident #40's nails and confirmed a dark substance was visible under the third and fourth right hand nails. Nurse #2 added nail care should occur more frequently to Resident #40 due to the history of using her fingers to eat, as well as smearing feces on herself and the bed. Nurse #2 stated she would care for Resident #40's fingernails.

On 2/16/22 at 12:15 PM, Resident #40 was observed with clean fingernails to both hands.

NA #4 was interviewed on 2/16/22 at 2:00 PM and stated she worked with an agency and had been assisting the facility since November 2021. She explained nail care was completed during personal care when needed but was unaware Resident #40 needed nail care.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. She

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stated it was her expectation for nail care to be provided during personal care tasks and if a NA was not able to complete the task she would expect the nurse to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #40 as there was no documentation to show this had or had not been completed or attempted.

4b) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and osteoarthritis.

Resident #40's active care plan, last reviewed on 12/2/21, included a focus area for Activities of Daily Living (ADL) self-performance deficit. The interventions included staff assistance with grooming and personal hygiene.

The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment. She required extensive assistance with personal hygiene and bathing.

A review of Resident #40's February 2022 physician orders revealed an order for Ketoconazole Shampoo (an antifungal shampoo) 2% to be applied to the scalp topically every evening shift on Monday and Thursday for tinea versicolor (a common fungus). Use on the scalp and hair and rinse well on shower days. This order was initiated on 5/20/20.

Resident #40's room history was reviewed and indicated she had been in the same room since 7/2/21 with a scheduled shower/shampoo on Tuesday and Friday during the day shift (7:00 AM

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to 3:00 PM). She had a short stay in a different room on the same hallway from 1/25/22 to 2/9/22 with the shower/shampoo scheduled on Wednesday and Saturday during the day shift.

A review of the February 2022 Medication Administration Record (MAR) revealed the Ketoconazole shampoo was signed as provided to Resident #40 on Monday and Thursdays as ordered (2/3/22, 2/7/22 and 2/14/22).

On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in bed eating lunch. Her hair was noted to be greasy in appearance, matted to the back of her head and a small braid was visible to the lower left backside of her hair.

A phone interview was completed with a family member of Resident #40 on 2/14/22 at 2:31 PM, who stated she wondered if she was getting her shampoos as scheduled as her hair appeared to be unbrushed and greasy when a recent visit occurred.

Resident #40 was observed on 2/15/22 at 10:42 AM sitting up in her bed. Her hair was noted to be unbrushed and matted in the back and the small braid to the lower left backside of her hair was undisturbed.

Nurse #1 was interviewed on 2/15/22 at 3:54 PM, who had signed the February 2022 MAR, that Resident #40 received Ketoconazole shampoo on 2/14/22. The nurse stated she had assumed it was done by the Nurse Aide (NA) because they didn't tell her it wasn't done. Nurse #1 added she had not verified the shampoo had been provided as ordered.

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On 2/16/22 at 8:30 AM, an interview occurred with Nurse #3. She had signed off on the February 2022 MAR that Resident #40 received Ketoconazole shampoo on 2/3/22 and 2/7/22. Nurse #3 stated she didn't verify with the NA that the shampoo had occurred but had assumed it had since the NA had not told her otherwise.

NA #4 was interviewed on 2/16/22 at 2:00 PM and stated she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM (first) and 3:00 PM to 11:00 PM (second) shifts. NA #4 was familiar with Resident #40 and was often assigned to care for her when she worked. NA #4 was unaware Resident #40 required to be shampooed with Ketoconazole.

On 2/17/22 at 9:35 AM, NA #1 was interviewed and stated she worked both the first and second shifts and was often assigned to Resident #40 when she worked. NA #1 was unaware Resident #40 required Ketoconazole shampoo.

A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM. She indicated she worked with an agency, had been assisting the facility since December 2021 and worked both first and second shifts. NA #12 was assigned to Resident #40 on 2/14/22 second shift. She stated Resident #40 was scheduled for showers/shampoos on the first shift, so she had not provided one to her on 2/14/22. NA #12 added she was unaware Resident #40 was to be shampooed with Ketoconazole.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The

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DON felt the lack of follow through to ensure Resident #40 received her medicated shampoo was lack of accountability and expected all orders to be followed.

5) Resident #54 was admitted to the facility on 9/1/17 with diagnoses that included history of a stroke, diabetes type 2 and osteoarthritis.

A review of the physician orders revealed an order dated 2/27/20 for weekly diabetic nail care (cleaned and trimmed if needed) to be completed by the evening nurse on Thursdays.

Resident #54's active care plan, last reviewed on 12/6/21, included the following focus areas:
- Activities of Daily Living (ADL) self-performance deficit.
- Actual impairment to skin integrity. The interventions included to keep fingernails short.

The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #54 was cognitively intact and required extensive assistance for personal hygiene.

The February 2022 Treatment Administration Record (TAR) indicated Resident #54 received diabetic nail care on 2/3/22 but was not initialed as received on 2/10/22.

A review of the nursing progress notes from 4/1/21 to 2/16/22 revealed no refusals of nail care documented.

An interview and observation was made of Resident #54 on 2/14/22 at 9:30 AM while he was

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lying in bed. He was noted to have long fingernails to the thumb and first and second fingers to the left hand. Resident #54 commented that he "would like to have nice, manicured nails" all the time.

Nurse #1 was interviewed on 2/15/22 at 3:54 PM and explained Resident #54's nail care was completed by the nursing staff due to his diabetic status. She was assigned to Resident #54 on 2/10/22 and after reviewing the February TAR, stated she must not have had time to complete his nail care. Nurse #1 added she had no difficulty with providing nail care to Resident #54 in the past.

On 2/16/22 at 8:30 AM, NA #1 was interviewed and explained the only nail care she completed was with the nail brush when needed during personal care. Resident #54 required nursing staff to care for his nails as he was a diabetic.

Resident #54 was observed on 2/16/22 at 3:37 PM with long fingernails to the left thumb, first and second fingers. He repeated he would prefer to have well-manicured nails short and equal in length.

On 2/16/22 at 3:45 PM, the Registered Nurse (RN) Supervisor observed Resident #54's left hand with long nails to the thumb, first and second fingers. She was unable to state why nail care had not been completed.

An interview was conducted with Nurse #3 on 2/17/22 at 3:20 PM and had initialed nail care had been completed for Resident #54 on 2/3/22. Nurse #3 stated she has had no difficulty in rendering nail care to Resident #54 but added

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F 677	Continued From page 81 often times she would sign off for the nail care prior to rendering and a lot of the time would get pulled away to do something else before she made it to Resident #54's room to render the nail care. The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. She stated it was her expectation for nail care to be provided as ordered for diabetic residents.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide one-to-one (1:1) visits and sensory stimulation for a resident who required specialized activities due to his severe cognitive impairment. This was for 1 (Resident #42) of 1 resident reviewed for activities. The findings included: Resident #42 was admitted on 11/25/15 with anoxic brain damage and dysphagia.	F 679	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	3/29/22

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F 679	Continued From page 82 Resident #42's quarterly Minimum Data Set (MDS) dated 1/31/22 indicated severe cognitive impairment and he exhibited no behaviors. Resident #42's activity care plan last revised 1/10/22 read he mostly participated in individual activities and required interactive sensory stimulation items and techniques. He enjoyed sitting at the nurses station to people watch and being up out of bed most of the time. Interventions included assisting Resident #42 to and from activities and provide 1:1 activities throughout the week. Resident #42's electronic medical record did not include an activity assessment or provision of 1:1 activities. An observation was conducted on 2/14/22 at 12:20 PM of Resident #42. He was lying in bed and appeared restless while his roommate was observed eating his lunch. Resident #42 had an order for nothing by mouth and received all of his nutrition through a feeding tube. He did not have any sensory objects within his reach. An interview was conducted with the Administrator on 2/14/22 at 2:40 PM. He stated the new Activity Director (AD) started in early December 2021 but she was on vacation from 2/9/22 until 2/16/22. He stated the facility receptionist was supposed to proving activities while the AD was gone but she called out so Nursing Assistant (NA) #13 had been helping. He said the receptionist and NA #13 were expected to provide any 1:1 visits that were needed. Another observation was conducted on 2/14/22 at 4:25 PM of Resident #42. He was lying in bed	F 679	corrected by the dates indicated. F679 The facility failed to provide one to one visits and sensory stimulation for a resident who required specialized activities due to sever cognitive impairment. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident's #42 the activity director provided 1:1 visits and sensory stimulation beginning on 3/2/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/09/2022 the Activity Director and the MDS coordinator audited all other residents for the need for the provision of one to one visits and sensory stimulation. Results: 4 additional residents were identified with a need for one to one activities. No additional residents were identified needing sensory stimulation. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/14/2022, the Administrator educated the Activity Coordinator on the following: • F679 regulation for the provision of activities that meet the needs of residents such as one to one activities and sensory stimulation. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 679	Continued From page 83 and appeared restless. He did not have any sensory objects within his reach. He had not been up out of the bed from 9:00 AM until 5:00 PM on 2/14/22. An observation was conducted on 2/15/22 at 9:42 AM of Resident #42. He was lying in bed and appeared restless. He did not have any sensory objects within his reach. An interview was conducted on 2/15/22 at 10:49 AM with NA #13. She stated it was her understanding that only group activities were to be completed. She stated, "I'm not good at activities so I only do pretty nails and crafts. An interview was conducted on 2/15/22 at 9:53 AM with Nursing Assistant (NA) #10. She stated she was an agency aide and had not worked with Resident #42 very long. She stated he was in constant motion while in bed. NA #10 stated she had not gotten him up to his Broda wheelchair because she was concerned that he could fall out of the wheelchair due to his continuous movements. A Broda wheelchair was designed to provide a full line of tilt-in-space and comfort for long-term residents. An observation was conducted on 2/15/22 at 12:45 PM, 3:10 PM and at 4:50 PM. Resident #42 remained in bed with no sensory items in his reach. An observation was conducted on 2/16/22 at 8:40 AM of Resident #42. He was lying in bed sleeping while his roommate ate his breakfast. An interview was conducted on 2/16/22 at 8:45 AM with NA #1. She started employment about a	F 679	all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor compliance utilizing the F679 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The tool will monitor to ensure that residents who require 1:1 activities or supervision are in compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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month ago and she had never observed Resident #42 up out of his bed or playing with any interactive toys.

An interview was conducted on 2/16/22 at 9:15 AM with the AD. She stated she just started her position in December 2021. She stated she was informed earlier today that the receptionist and NA #13 had been providing activities in her absence. The AD stated she was unable to find any documented evidence of 1:1 activities or activity attendance log for Resident #42 but stated he was up in his Broda wheelchair daily at the nurses' station and was provided sensory objects. The AD stated she was not aware that Resident #42 had not been observed out of his bed since 2/14/22.

An observation was conducted on 2/16/22 at 11:10 AM of Resident #42. He was lying in bed and appeared restless. He did not have any sensory objects within his reach.

An observation was conducted on 2/16/22 at 11:10 AM of Resident #42. He was up in his Broda chair self-propelling down the halls. The constant movements had subsided.

An interview was conducted on 2/17/22 at 9:55 AM with the Administrator. He stated he was not aware that Resident #42 was not being provided 1:1 visits or being gotten up out of bed for sensory stimulation.

An observation was conducted on 2/16/22 at 4:25 PM of Resident #42. He was sitting in his Broda wheelchair at the nurses station playing with an interactive sensory stimulation toy. He was still, smiling and absent of constant movements.

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F 684 SS=D	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, observations, staff and Wound Physician interviews, the facility failed to provide protective skin coverings as ordered (Resident #40) and failed to provide treatment to a surgical wound as recommended by the Wound Physician (Resident #46). This was for 2 of 22 residents reviewed for well-being. The findings included: 1) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and osteoarthritis. The physician orders revealed an order dated 3/26/20 to apply geri-sleeves (protective sleeves) to both hands/arms every shift for skin integrity. Resident #40's active care plan, last reviewed on 12/2/21, included the following focus areas: - Activities of Daily Living (ADL) self-performance deficit. The interventions included to apply geri-sleeves to both hands every shift while awake. - Fragile skin with increased risk for skin tears/injuries. Increased risk for bruising related	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 The facility failed to provide protective skin covering as ordered and to provide treatment to a surgical wound as ordered. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/15/2022 treatment as ordered was provided to the rt lower back surgical wound by the wound nurse for resident # 46. The treatment order was reviewed and corrected by the wound nurse to assure that the most current wound physician order was in place on	3/29/22

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F 684	Continued From page 86 to aspirin. The interventions included to wear protective sleeving to reduce the risk for skin tears. Apply geri-sleeves to both hands/arms every shift. The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and required extensive assistance with dressing. She was coded with skin tears present. A review of the February 2022 Treatment Administration Record (TAR) revealed the geri-sleeves were signed as being on Resident #40 on 2/14/22, 2/15/22 and 2/16/22 day shift (7:00 AM to 3:00 PM). Resident #40 was observed on 2/14/22 at 11:30 AM, while lying in bed with her eyes closed. Her arms were laying on top of the covers without any protective sleeves. On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in bed eating lunch. There were no protective sleeves present to her arms/hands. Resident #40 was observed on 2/15/22 at 10:42 AM sitting up in her bed. She was dressed in a hospital gown without any protective sleeving to her arms/hands. Another observation was made of Resident #40 on 2/15/22 at 12:15 PM with no protective sleeves present to her arms/hands. On 2/15/22 at 1:19 PM, Resident #40 was observed lying in bed with her eyes closed. There were no protective sleeving on her arms/hands.	F 684	2/15/2022. On 2/15/2022 the Nurse Consultant educated the wound nurse on the facility wound and treatment process and transcription of wound physician orders timely and accurately. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 2/23/2022 the Director of Nurses and Wound Nurse began auditing all residents with non-pressure ulcers to assure that the most current treatment order was in place and being provided as ordered. Results: 2_ of _2 residents with non-pressure ulcers had an accurate treatment order in place as recommended by the physician/wound physician and were receiving the treatment as ordered. This audit was completed as of 2/23 /2022. As of 2/23/2022 all residents with non-pressure ulcers were in compliance. As of 3/09/2022 wound orders received from the wound physician will be reviewed by the Wound Committee at the weekly wound meeting. The Wound Committee is comprised of the Director of Nurses, Registered Nurse Manager, Wound Nurse and Minimum Data Set Nurse and Dietary Manger. Results: All wound care orders current and reflect wound physician orders. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/09/2022 the Director of Nurses, Nurse Consultant and RN	

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F 684	Continued From page 87 Resident #40 was observed on 2/16/22 at 10:22 AM, dressed in a hospital gown without protective sleeving to her arms/hands. Nurse #2 was interviewed on 2/16/22 at 11:02 AM. She reviewed the February 2022 TAR where she had marked Resident #40 had geri-sleeves present to her arms/hands on 2/14/22, 2/15/22 and 2/16/22. She stated she "had assumed they were on" when she marked them on the TAR but she had not verified they were on. An observation was made of Resident #40 with Nurse #2, who confirmed they were not in place. Nurse Aide (NA) #4 was interviewed on 2/16/22 at 2:00 PM and stated she had worked at the facility since November 2021 and worked both the 7:00 AM to 3:00 PM (first) and 3:00 PM to 11:00 PM (second) shifts. NA #4 was familiar with Resident #40 and was often assigned to care for her when she worked. NA #4 was unaware Resident #40 required geri-sleeves on her arms. NA #4 was unaware of a care guide available for Resident #40. The Registered Nurse (RN) Supervisor was interviewed on 2/16/22 at 3:45 PM and stated she had just returned to work at the facility 3 weeks ago. She recalled Resident #40 required geri-sleeves due to her fragile skin but could not explain why staff were not ensuring they were in place as ordered. On 2/17/22 at 9:35 AM, NA #1 was interviewed and stated she worked both the first and second shifts and was often assigned to Resident #40 when she worked. NA #1 was unaware Resident #40 required geri-sleeves to her arms. She was	F 684	Supervisor began in-service education to all full time, part time, and as needed and agency nurses Topics included: • Following physician orders for wound treatments. • Confirming that new orders provided by the wound doctor or other physicians, are initiated timely and accurately. • How to apply these principles to their daily practice. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or designee will utilize the QA tool for the Quality of Care Process to monitor compliance with timely and accurate transcription implementation of wound physician orders. The Director of Nurses and/or designee will monitor two residents with non-pressure ulcers weekly for 2 weeks, then monthly for 3 months for accuracy and timely implementation of wound treatment orders by the wound physician. This tool will be completed as	

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F 684	Continued From page 88 unaware of a care guide available for Resident #40. The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The DON felt the lack of follow through to ensure Resident #40 had the geri-sleeves in place as ordered was due to lack of accountability and expected all orders to be followed. 2. Resident #46 was admitted to the facility on 1/10/22 with multiple diagnoses including status post T10 (thoracic vertebra) - L 4 (lumbar spine) spinal fusion and L4 vertebroplasty (a procedure for stabilizing compression fractures in the spine). The admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated that Resident #46's cognition was intact, and she had 1 unstageable pressure ulcer. Resident #46 had a doctor's order dated 1/12/22 for Santyl (a debriding agent that promotes wound healing) - apply to right lower back daily for wound healing. Resident #46's care plan dated 1/17/22 was reviewed. The care plan problem was "I currently have a pressure ulcer to my back and I am at risk for development of additional pressure ulcers due to decreased ability to reposition and incontinence. The approaches included administer treatment as ordered and consult with wound physician as needed/ordered. Resident #46 was followed by the Wound Physician weekly. The Wound Physician weekly notes were reviewed and indicated that the open wound on the right lower back was a surgical	F 684	stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.	

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F 684	Continued From page 89	F 684		

wound and was overlaying part of the incision. The weekly notes including assessments and treatment plans were as follows:

1/18/22 - post surgical - right lower back - 4.2 centimeter (cm) X (by) 2 cm. with 100% necrosis - treatment plan - Santyl ointment daily for 30 days
1/25/22 - post surgical - right lower back - 4 cm x 1.4 cm - 100% necrosis - treatment plan - Santyl daily for 23 days
2/4/22 - post surgical - right lower back - 4 cm x 1.5 cm - 95 % necrosis - treatment plan - Santyl daily
2/8/22 - post surgical - right lower back - 3.8 x 1.2 cm - 95% necrosis - exudate -moderate serosanguinous - treatment plan - Santyl for 9 days and Gentamycin ointment (used to treat skin infection) for 30 days

The Wound Nurse was observed on 2/15/22 at 8:45 AM during the dressing change. The wound to the right lower back was assessed and measured by the Wound Physician. The measurements were 3.5 x 1.2 cm, 100% necrosis and with moderate amount of serosanguinous exudate. The Wound Nurse cleaned the wound with wound cleanser, Santyl ointment was applied and covered with dry dressing. The Wound Nurse was not observed to use Gentamycin to the wound.

The Wound Nurse was interviewed on 2/15/22 at 1:32 PM. She stated that she started as the Wound Nurse in October 2021. She made rounds with the Wound Physician weekly and transcribed the treatment plan as recommended. She reviewed the Wound Physician note dated 1/18/22 and verified that the wound on the right

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F 684	Continued From page 90 lower back was a surgical wound and not a pressure ulcer. She also stated that she missed to transcribe the Gentamycin as recommended by the Wound Physician on 2/8/22. The Wound Physician was interviewed on 2/17/22 at 1:20 PM. She reported that she made rounds with the Wound Nurse weekly on Tuesday. She provided her notes to the Wound Nurse that same day and she expected her to transcribe the treatment plan she had recommended. She further indicated that she was not aware that the treatment she had recommended (Gentamycin) was not transcribed. She was informed last Tuesday (2/15/22) that the Gentamycin was not available and so she ordered to use Bacitracin (used to prevent wound infection) instead. The Wound Physician explained that Resident #46 was admitted with the wound on her back from her back surgery. The wound was getting better however last week there was a moderate amount of drainage. Her attending physician had already put her on Keflex (an antibiotic) by mouth so the Gentamycin was just an additional treatment. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as the DON of the facility in January 2022. She stated that the Wound Nurse was new to her position but that was not an excuse not to transcribe the treatment orders. The DON stated that she expected the treatment plan to be transcribed and implemented as recommended by the Wound Physician.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/29/22

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F 686	Continued From page 91 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff, resident, facility Wound Physician, Medical Director (MD) and Wound Clinic Nurse Practitioner (NP) interviews, the facility failed to implement an order for a specialty mattress (Resident #26) and failed to provide wound care as ordered and as recommended by the Wound Physician (Resident #17, #54 and #14). This was for 4 of 6 residents reviewed for pressure ulcers. The finding included: 1. Resident #26 was admitted on 3/5/21 with paraplegia, osteomyelitis and a stage 4 pressure ulcer to his right hip. A review of a wound clinic note dated 11/10/21 read an order to upgrade his bed to either a Clinitron bed (minimizes pressure, friction, heat and moisture. It also can help restore the flow of oxygen to tissues to facilitate the delivery of nutrients to the wound areas) or a Dolphin Bed (treats pressure ulcers by maintaining proper tissues symmetry to sustain blood flow, alleviate	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 The facility failed to provide an ordered specialty mattress and to provide wound care as ordered. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/17/2022 the Director of Nurses verified with the recommending wound clinic that the equalizer mattress was an acceptable level 2 specialty mattress for	

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F 686	Continued From page 92 pressure ulcer pain and promotes healing). The note indicated the MD was notified of the new order on 11/11/21. Review of Resident #26's electronic medical record (EMR) revealed evidence of refusals of skin assessments and refusals of his pressure ulcer treatments. Review of Resident #26's weekly skin and wound evaluation dated 11/30/21 read he developed an stage 4 pressure ulcer to his left ischium and another stage 4 pressure ulcer to his right ischium on 1/26/22. Review of Resident #26 revised pressure ulcer care plan dated 12/16/21 read he was to have a pressure reducing mattress. He was also care planned on 12/16/21 for resistance to wound care and pressure relieving measures. The intervention read to allow Resident #26 make decisions about his treatment regime to promote a sense of control. Review of Resident #26's quarterly Minimum Data Set (MDS) dated 1/2/22 indicated he was cognitively intact and coded for rejection of care. He was coded for three pressure ulcers and a pressure relieving device to his bed. Review of Resident #26's February 2022 Physician orders included an order dated 3/5/21 which read: low air loss mattress. Check for proper function and inflation every shift. Additional orders dated 11/11/21 read Resident #26 was only to be out of bed for 2 hours in a 24 hour period and to turn and reposition every 2 hours. An interview was conducted on 2/14/22 at 10:44	F 686	resident #26 wound needs. The specialty mattress was applied to the resident's bed on 2/17/2022. On 2/16/2022 treatment as ordered was provided to the left heel by the wound nurse for resident # 17. The treatment order was reviewed by the wound nurse and updated to assure that the most current wound physician order was in place on 2/16/2022. On 2/16/2022 treatment as ordered was provided to the rt buttock by the wound nurse for resident # 54. The treatment order was reviewed by the wound nurse and updated to assure that the most current wound physician order was in place on 2/16/2022. On 2/16/2022 treatment as ordered was provided to the rt thigh and left heel of resident # 14 by the wound nurse as ordered. The treatment order was reviewed by the wound nurse and updated to assure that the most current wound physician order was in place on 2/16/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 2/23/2022 the Director of Nurses and Wound Nurse began auditing all residents with pressure ulcers to assure that the most current treatment order was in place and being provided as ordered. Results: 5 of 5 residents with pressure ulcers had an accurate treatment order in place as recommended by the physician/wound physician. This audit was completed as of 2/23 /2022. As	

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F 686	Continued From page 93 AM with Resident #26. He stated he went to the wound clinic at the hospital for a monthly wound assessment and evaluation. Resident #26 stated the wound clinic NP wrote an order for him to have a specialty mattress in November 2021 and to date, he has been on the same air mattress. He stated the previous Administrator apparently never ordered the mattress. Resident #26 stated he had developed 2 more pressure ulcers since November 2021. Resident #26 denied that he refused his skin assessments and wound treatments. A wound care observation was completed on 2/15/22 at 2:20 PM with the Director of Nursing (DON). Resident #26 was in bed on a low pressure air mattress. The DON stated Resident #26 had been on the same mattress and the mattress was never upgraded to her knowledge. She stated she was not aware of the wound clinic recommendation dated 11/10/22 for a Clinitron bed or a dolphin surface mattress. An interview was conducted on 2/16/22 at 10:30 AM with the facility Wound Nurse. She stated Resident #26 went to the wound clinic at the hospital monthly for a wound evaluation. She stated Resident #26 was noncompliant with his wound care and recommendations. The Wound Nurse stated she was not aware that there was an order on 11/10/21 about a Clinitron bed or a Dolphin bed. On 2/16/22 at 3:10 PM, the facility Nurse Consultant provided a invoice dated 12/20/21 for a Equalizeaire Plus mattress (a bed that provides both alternating pressure and low air loss to optimize pressure redistribution) but it was back ordered. She stated apparently the previous	F 686	of 2/23/2022 all residents with pressure ulcers were in compliance. On 2/21/2022 the Director of Nurses and Wound Nurse audited all residents with orders for specialty mattresses to assure the appropriate mattress was in place with no other incidents found. On 2/23/2022 the Director of Nurses educated the wound nurse on the facility wound and treatment process to include ensuring that recommendations by the wound physician are being transcribed and implemented timely and accurately. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 3/09/2022 the Director of Nurses, Nurse Consultant and RN Supervisor began in-service education to all full time, part time, and as needed and agency nurses Topics included: • Following physician orders for wound treatments. • Confirming that new orders provided by the wound doctor or other physicians, are initiated timely and accurately. • Follow through on orders for specialty mattress process • How to apply these principles to their daily practice. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified	

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Administrator ordered the Equalizeaire Plus because it might be comparable to a Clinitron or a Dolphin bed. The backorder invoice dated 12/20/21 was initialed by the current Administrator with the date of 2/15/22. She stated the facility did have a Supra DPS alternating bubble pad mattress available. The Nurse Consultant stated the DON was waiting on a return call from the hospital wound clinic to confirm that the Supra DPS alternating bubble pad mattress (low air loss mattress for the treatment of pressure ulcers) would be acceptable to use until the Equalizeaire Plus mattress arrived.

An interview was conducted on 2/17/22 at 10:12 AM with the DON. She stated she called the hospital wound clinic and they said the Supra DPS alternating bubble pad mattress would be acceptable until the Equalizeaire Plus mattress arrived in April 2022. She stated it would be placed on his bed by the end of the day.

A telephone interview was conducted on 2/17/22 at 5:29 PM with the hospital wound clinic NP treating Resident #26. She stated she was contacted yesterday by the DON regarding his mattress. She stated she was not aware that the order dated 11/10/21 for the specialty bed was not implemented. The wound clinic NP stated Resident #26 was not doing things to help with the wound healing but the specialty bed would improve his wound healing status as long as Resident #26 was complaint. She stated she expected the facility to provide what Resident #26 needed to promote wound healing.

An telephone interview was conducted on 2/17/22 at 4:56 PM with the MD. He stated Resident #26 was known to refuse skin assessments,

nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nursing, and/or designee will utilize the QA tool for Pressure Ulcer Prevention and Treatment to monitor compliance with the timely and accurately transcribing wound physician orders for implementation. The Director of Nurses, and/or designee will monitor three residents with pressure ulcers weekly for 2 weeks, then monthly for 3 months for accuracy of wound treatment orders and for placement of specialty mattresses as ordered. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.

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medications and wound care. The MD further stated he expected timely follow up and implantation of any recommendations made by the hospital wound clinic NP.

An interview was conducted on 2/17/22 at 6:00 PM with the DON. She stated Resident #26's wound clinic order for a specialty bed should have been implement with the type of bed recommended or with a comparable mattress/ bed.

2) Resident #17 was originally admitted to the facility on 3/1/21 with a recent readmission on 1/28/22. She had multiple diagnoses that included osteomyelitis (inflammation of the bone caused by an infection) of the vertebra and sacral region and pressure ulcer of the sacral region.

Resident #17's active care plan, last reviewed 11/22/21, included a focus area for pressure ulcer to the sacral area and remained at risk for development of additional pressure ulcers. The interventions included to administer treatments as ordered and monitor for effectiveness.

A quarterly Minimum Data Set (MDS) assessment dated 12/11/21 indicated Resident #17 was cognitively intact and had 1 stage 3 (a sore that extends into the tissue beneath the skin forming a crater) pressure ulcer.

Review of Resident #17's medical record indicated she was in the hospital from 1/18/22 to 1/28/22 for treatment and surgical debridement of the sacral wound. Upon her return to the facility there was an order to continue with Aquacel (a dressing that forms a gel on contact with wound fluid to promote healing) placed with a border dressing to the sacral wound daily.

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A review of the active physician orders included an order dated 1/31/22 to cleanse the right heel with soap and water, apply skin prep, and heel protector every day for a deep tissue injury (an injury to the underlying tissue below the skin's surface that results from prolonged pressure in that area) that was present on readmission to the facility.

Review of the Wound Physician Wound Evaluation and Management Summary for 2/4/22 indicated the following:
- Stage 4 (a sore that extends below the subcutaneous fat into the deep tissue) pressure wound of the sacrum measured 10.5 centimeters (cm) in length, 10 cm in width and 4 cm in depth. The treatment recommendation was for Calcium Alginate with silver (a sterile primary dressing for wound with moderate to heavy drainage) and Anasept gel (an antimicrobial gel that helps with wound healing) to the wound bed, cover with gauze and a foam border dressing daily.
- Unstageable deep tissue injury of the right heel measured 5 cm in length and 6 cm in width. The treatment recommendation was to apply skin prep to the area daily and keep heel off the bed.
- Unstageable deep tissue injury of the left heel measured 1.8 cm in length and 1.5 cm in width. The treatment recommendation was to apply skin prep to the area daily and keep heel off the bed.

Resident #17's February 2022 Treatment Administration Record (TAR) from 2/1/22 to 2/8/22 revealed the sacral wound was cleansed with wound cleaner, had Aquacel placed on wound bed and covered with dressing daily and the right heel was cleansed with skin prep applied daily. The TAR did not reflect a treatment was

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provided to Resident #17's left heel.

Review of a Wound Physician Wound Evaluation and Management Summary dated 2/8/22 indicated Resident #17 revealed the following:
- Stage 4 pressure wound of the sacrum measured 11 cm in length, 11 cm in width and 4.3 cm in depth. The treatment recommendation was for Calcium Alginate with Anasept gel to the wound bed, cover with gauze and a foam border dressing twice a day.
- Unstageable deep tissue injury of the right heel measured 5.5 cm in length and 5.3 cm in width. The treatment recommendation was to apply skin prep to the area daily and keep heel off the bed.
- Unstageable deep tissue injury of the left heel measured 1.1 cm in length and 1.4 cm in width. The treatment recommendation was to apply skin prep to the area daily and keep heel off the bed.

On 2/8/22 the physician orders reflected a change to cleanse the sacral area with wound cleanser, place Aquacel cover with Mepilex twice a day.

A review of the February 2022 Treatment Administration Record from 2/8/22 to 2/14/22, indicated Resident #17's sacral wound was cleansed with wound cleaner, had Aquacel placed on wound bed and covered with dressing twice a day and the right heel was cleansed with skin prep applied daily. The TAR did not reflect a treatment was provided to Resident #17's left heel.

Unable to observe the weekly wound assessment with the wound nurse and facility Wound Physician on 2/15/22 at 10:20 AM, as Resident #17 was out of the facility at a doctor's

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appointment.

On 2/15/22 at 12:13 PM, Resident #17 was observed lying in her bed looking out the window. When asked if observation of her wound care could occur she stated, "I'd rather not."

The wound nurse was interviewed on 2/16/22 at 10:30 AM and explained she had been the wound nurse at the facility since October 2021 and only did the wound rounds with the Wound Physician, who was at the facility every Tuesday. They evaluated the residents with pressure ulcers that were not seen by the wound clinic and received treatment orders from the Wound Physician. The wound nurse stated she was able to receive the Wound Physician's Wound Evaluation and Management Summary by the afternoon on Tuesdays and tried to review the Wound Physician's recommendations. After reviewing Resident #17's active physician orders, the February 2022 TARs and the Wound Evaluation and Management Summaries dated 2/4/22 and 2/8/22, the wound nurse agreed the orders were not as recommended by the Wound Physician and did not include the treatment to Resident #17's left heel. The wound nurse stated she "could do a better job of reviewing the reports and making sure the treatment orders were accurate with what the Wound Physician recommended."

The facility Wound Physician was interviewed via phone on 2/17/22 at 1:00 PM and stated she was unaware the wound treatments recommendations were not being followed as written but would expect them to be followed for optimal wound healing.

The Director of Nursing (DON) was interviewed

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on 2/17/22 at 5:33 PM and indicated she had started employment at the facility in January 2022. The DON stated it was her expectation for the facility Wound Physician's recommendations to be followed accurately and completely.

3) Resident #54 was admitted to the facility on 9/1/17 with diagnoses that included diabetes type 2, osteoarthritis, and gout.

Resident #54's active care plan, last reviewed on 12/6/21, included a focus area for actual impairment to skin integrity of the sacral area. The interventions included to keep skin clean and dry and use protective barrier ointment to sacrum.

A quarterly Minimum Data Set (MDS) assessment dated 1/26/22 indicated Resident #54 was cognitively intact and had 1 stage 3 pressure ulcer.

A review of Resident #54's active physician orders revealed an order dated 1/11/22 to cleanse the wound to the right buttock with wound cleanser, apply Hydrofera blue and cover with foam border dressing every day and as needed.

Review of the Wound Physician Wound Evaluation and Management Summary for 2/4/22 revealed a Stage 3 pressure wound of the right buttock measured 4.5 cm in length, 1.8 cm in width and 0.1 cm in depth. The treatment recommendation was for Hydrofera blue covered with a foam border dressing daily.

A Wound Physician Wound Evaluation and Management Summary for 2/8/22 indicated Resident #54's Stage 3 pressure area to the right

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buttock measured 4.2 cm in length, 2.0 cm in width and 0.1 cm in depth. The treatment order recommendation changed to Hydrofera blue foam over collagen with Anasept gel covered with gauze every day.

Resident #54's February 2022 Treatment Administration Record (TAR) from 2/1/22 to 2/15/22 indicated the sacral wound was cleansed with wound cleaner, Hydrofera blue covered with a gauze dressing daily and as needed.

An observation of Resident #54's wound care was completed with the wound nurse and facility Wound Physician on 2/15/22 at 10:23 AM. Resident #54 was observed lying in bed listening to preaching service through headphones. The pressure area to the right buttock measured 4.2 cm in length, 1.6 cm in width and 0.1 cm in depth. The periwound was pink in color and the wound bed was white. There was no drainage or odor present. The facility Wound Physician stated the wound had stalled in the healing process and that a change in the treatment order had occurred recently in hopes of seeing more improvement in the pressure wound.

On 2/15/22 the physician orders and February 2022 TAR, reflected a change to cleanse the right buttock wound with wound cleaner, apply Anasept gel, cover with collagen, place Hydrofera blue over and cover with gauze daily and as needed.

The wound nurse was interviewed on 2/16/22 at 10:30 AM and explained she had been the wound nurse at the facility since October 2021 and only did the wound rounds with the Wound Physician, who was at the facility every Tuesday. They evaluated the residents with pressure ulcers that

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were not seen by the wound clinic, and she received treatment orders from the Wound Physician. The wound nurse stated she was able to receive the Wound Physician's Wound Evaluation and Management Summary by the afternoon on Tuesdays and tried to review the Wound Physician's recommendations. After reviewing Resident #54's active physician orders, the February 2022 TARs and the Wound Evaluation and Management Summaries dated 2/4/22 and 2/8/22, the wound nurse agreed the orders were not as recommended by the Wound Physician, but she had updated the orders on 2/15/22. The wound nurse stated she "could do a better job of reviewing the reports and making sure the treatment orders were accurate with what the Wound Physician recommended. "

The facility Wound Physician was interviewed via phone on 2/17/22 at 1:00 PM and stated she was unaware the wound treatments recommendations were not being followed as written but would expect them to be followed for optimal wound healing.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM and indicated she had started employment at the facility in January 2022. The DON stated it was her expectation for the facility Wound Physician's recommendations to be followed accurately and completely.

4. Resident #14 was admitted to the facility on 9/4/17 with multiple diagnoses including developmental disorder that affects communication and behavior. The quarterly Minimum Data Set (MDS) assessment dated 12/6/21 indicated that Resident #14 had moderate cognitive impairment, dependent on the staff for bed mobility and had 1 stage 4 pressure

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ulcer that was present on admission.

Resident #14's care plan dated 12/6/21 was reviewed. The care plan problem was "I currently have a pressure ulcer". The approaches included to administer treatments as ordered and to monitor for effectiveness, and to consult with the Wound Physician as needed/ordered.

Resident #14 was followed by the Wound Physician weekly. The note dated 12/14/21 indicated that Resident #14 had developed pressure ulcers on his right thigh (unstageable) and left heel (unstageable) and were treated with skin prep (a liquid forming skin protectant used on intact or damaged skin to help prevent irritation). The note dated 2/8/22 indicated that the right thigh pressure ulcer measured 3-centimeter (cm) x (by) 1.9 cm x 1 cm. with 10% necrosis and with moderate amount of serosanguinous exudate. The treatment plan was to treat the right thigh pressure ulcer with Alginate Calcium with silver (a highly absorbent dressing that promotes healing and formation of granulation tissue) daily for 9 days. The left heel pressure ulcer measured 5.5 cm x 3.8 cm x 0.1 cm with 70 % granulation tissue and with moderate amount of serosanguinous exudate. The treatment plan was Alginate Calcium with silver and Gentamycin ointment (used to treat skin infection) daily for 7 days.

Resident #14 had a doctor's order dated 1/26/22 to clean the right thigh wound with wound cleanser, apply Alginate Calcium with silver and cover with foam dressing daily and as needed. On 2/5/22, there was an order to clean the left heel pressure ulcer with wound cleanser, apply

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Gentamycin ointment and then wrap with kerlex daily and as needed.

Resident #14 was observed during the dressing change on 2/15/22 at 9:25 AM. The pressure ulcers on the right thigh and left heel were assessed and measured by the Wound Physician. The right thigh ulcer measured 1.5 cm x 1.3 cm x 1.1 cm with 5% necrosis. The left heel pressure ulcer measured 1 cm x 1 .3 cm x 0.1 cm with 100 % granulation tissue. The Wound Nurse was observed to clean the right thigh ulcer with wound cleanser and Santyl ointment (a debriding agent that promotes wound healing) was applied and was covered with dry dressing. The treatment that was recommended and ordered by the Wound Physician for Alginate Calcium was not followed. The Wound Nurse proceeded to clean the left heel pressure ulcer with wound cleanser and Gentamycin ointment was applied, covered with dry dressing, and secured with kerlex. The treatment that was recommended by the Wound Physician for Alginate Calcium was not followed.

The Wound Nurse was interviewed on 2/15/22 at 1:32 PM. She stated that she started as the Wound Nurse in October 2021. She made rounds with the Wound Physician weekly and transcribed the treatment plan as recommended. She reviewed the Wound Physician note dated 2/8/22 and the order to use Alginate Calcium to the right thigh pressure ulcer. She indicated that the nurses were providing the treatment daily and she was not familiar with the treatment order. She also stated that she missed to transcribe the Alginate Calcium to the left heel as recommended by the Wound Physician on 2/8/22.

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F 686	Continued From page 104 The Wound Physician was interviewed on 2/17/22 at 1:20 PM. She reported that she made rounds with the Wound Nurse weekly on Tuesdays. She provided her notes to the Wound Nurse that same day and she expected her to transcribe the treatment plan she had recommended. She further indicated that she was not aware that the treatment she had recommended was not transcribed and implemented. The Wound Physician explained that Resident #14 was high risk for the development of pressure ulcers. He was a quadriplegic (paralysis of all limbs) and had developmental disorder. He had been on air mattress and was on tube feeding and believed that his ulcers were unavoidable. He was being followed weekly and his ulcers were improving. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that the Wound Nurse was new to her position but that was not an excuse not to transcribe and to follow the treatment orders. The DON stated that she expected the treatment plan to be transcribed and implemented as recommended and as ordered by the Wound Physician.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		3/29/22

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F 689	Continued From page 105 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to prevent repeated falls by not providing effective interventions after each fall (Resident #16) for 1 of 4 sampled residents reviewed for accidents. Resident #16 sustained fracture of the fingers on 9/10/21 and left and right hip fractures on 9/24/21 after the fall. Findings included: Resident #16 was admitted to the facility on 6/1/21 with multiple diagnoses including Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS) assessment dated 12/9/21 indicated that Resident #16 had severe cognitive impairment and needed supervision with 1-person physical assist with transfers and ambulation in room. The assessment further indicated that the resident had 2 or more falls since admission, reentry, or prior assessment. Resident #16's care plan that was initiated on 6/28/21 was reviewed. The care plan problem was "I have had actual fall with risk for further". The goal was "my risk for future falls will be minimized through current interventions". The approaches included encourage me to call for assistance prior to transfers (10/1/21), encourage me to lock my breaks before standing up (10/1/21), encourage me to use my walker when ambulating (6/28/21), encourage me to wear non-slip socks when not wearing shoes (6/28/21), ensure that call light is within reach (6/28/21), Physical therapy (PT) to evaluate as needed (6/28/21), hipster to be worn at all times	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The facility failed to prevent repeated falls by not providing effective interventions after each fall. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #16, a PT safety screen was completed on the resident on 03/10/2022 by the Physical Therapist. Toileting before meals and at bedtime was added as an intervention on 2/25/2022 to the care plan. Falls for resident #16 were reviewed for the last 60 days by the Director of Nurses and MDS nurse on 3/07/2022 to assure all appropriate fall interventions were reflected on her care plan and have been carried out. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/09/2022 -03/11/2022 the Director of Nursing and Minimum Data Set Nurse audited all current residents with falls in	

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F 689	Continued From page 106 (10/15/21), make sure that I have non-slip shoes that fit appropriately (6/28/21), observe me for possible side effects from medications that may affect my gait and balance and report to nurse if I have change in my gait or balance (10/7/21) and reinforce safety reminders frequently (10/1/21). Resident #16's incident reports were reviewed. The reports revealed that the resident had 5 falls since admission to the facility and 2 of the 5 falls, the resident sustained fractures. The report dated 9/9/21 at 12:20 AM revealed that Resident #16 was observed on the floor outside of her bathroom after hearing the roommate yelling "she fell". The resident was assessed for injury and no deformity noted to the lower extremities. The root cause of the fall was determined to be self- toileting at night. The intervention was to check frequently for needs. There was no new intervention added to the care plan until 10/1/21. The report further indicated that after the resident was placed in bed, she complained of pain to her right thumb and right hip/leg, the physician was informed, and x-ray was ordered. The x-ray report dated 9/10/21 revealed acute, non-displaced fracture at base of first distal phalanx and mild subluxation at first metacarpophalangeal joint. The nurse's note dated 9/11/21 at 4:32 AM, the physician was notified of the x-ray report, and he ordered to maintain the broken fingers taped together. The report dated 9/15/21 at 6:59 AM revealed	F 689	the past 30 days to ensure that all appropriate interventions were identified and in place on the care plan and carried out with no further concerns noted. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 03/10/2022, the Nurse Consultant educated the interdisciplinary team (Director of Nursing, MDS Nurse, Dietary Manager, Business office manager, Medical Records director, Therapy manager, Activity Director and Administrator) on the following topics: • Root cause analysis and timely entry of fall interventions to the care plan. • Review of falls at Daily Stand Up meeting (Monday thru Friday) by the interdisciplinary team with addition of appropriate interventions to the care plan. Beginning on 3/10/2022 the Director of Nurses, Nurse Consultant and RN Supervisor educated all nurses and CNA's Full Time, Part Time, as needed and agency on implementation of fall interventions and accessing the resident kardex/care plan. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.	

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F 689	Continued From page 107 that Resident #16 was observed sitting on the floor at the doorway of room. Resident was assessed for injury. Range of motion to all extremities with no change in limitations noted. The root cause of the fall was determined to be self- toileting at night. The intervention was to check frequently for needs and frequent reminders to get assistance. There was no new intervention added to the care plan until 10/1/21. The nurse's note dated 9/15/21 at 9:41 AM revealed that Resident #16 noted to be in pain when trying to stand up. When asked, she stated that her hips hurt. The resident was medicated with Tramadol (a narcotic used to treat pain) and the physician was notified, and he ordered x-ray of bilateral hips and pelvis. The x-ray report dated 9/15/21 revealed no fractures. The nurse's note dated 9/23/21 revealed that Resident #16 continued not to bear weight on her right lower extremity, the physician was notified and computerized tomography CT) scan of the pelvis was ordered. The CT scan report dated 9/24/21 revealed displaced comminuted right superior pubic ramus fracture and nondisplaced left inferior pubis ramus fracture. The nurse's note dated 9/25/21 at 5:12 PM indicated that the physician called, and Resident #16 had fractures to her right and left pelvis. The physician had ordered for weight bearing as tolerated. The report dated 10/11/21 at 8:00 PM revealed	F 689	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure fall interventions implemented are carried out timely and have been entered into the resident car eplan. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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that Resident #16 was observed on the floor in front of her bed. Complete body assessment was completed with no redness, scratches or open areas noted. The root cause of the fall was determined to be confusion, poor safety awareness and self-transfers. The intervention was hipster for protection. There was new intervention added to the care plan to prevent further falls except for the hipster on 10/15/21.

The report dated 1/4/22 at 8:30 AM revealed that Resident #16 was observed on the floor by the bathroom door. The resident complained of lower back pain. The resident was educated the importance of using the wheelchair and calling for assistance by using the call bell. The report stated that the resident continued to ambulate independently to the bathroom without calling for help or use of wheelchair. Tramadol was administered for pain. The physician was notified, and x-ray was ordered. The x-ray report did not show any acute fracture. The root cause of the fall was dementia with resident complaining of forgetfulness and not calling for assistance. The report did not include intervention to prevent further fall and there was no new intervention added to the care plan after the fall to prevent further fall.

The report dated 2/4/22 at 4:14 PM revealed that Resident #16 was observed on the floor beside her bed. Head to toe assessment was completed with no injury noted. The root cause of the fall was determined to be resident was leaning against the side of the bed and was found on the floor wearing improper footwear. Intervention was to ensure when out of bed, resident was wearing non-skid socks. There was new intervention added to the care plan after the fall to

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prevent further falls.

Resident #16 was observed up in wheelchair in her room on 2/15/22 at 12:45 PM and on 2/16/22 at 9:27 AM, and 1:40 PM. There was a walker (folded) noted between the wall and the nightstand and was not within reach of the resident.

The Registered Nurse (RN) Supervisor was interviewed on 2/16/22 at 1:39 PM. She reported that they (Director of Nursing (DON), Support Nurse, MDS Nurse, Rehabilitation Director and Dietary Manager) used to have a clinical meeting daily Monday through Friday and discussed falls, what and how it happened and what intervention to put in place. The RN Supervisor reported that the MDS Nurse was supposed to add the interventions discussed during the meeting to the care plan. She stated that due to staff turn -over, the clinical meeting did not happen consistently.

Nurse Aide (NA) #1, assigned to Resident #16 was interviewed on 2/16/22 at 1:41 PM. NA #1 stated that she started working at the facility a month ago. She stated that the resident was confused, frequently continent of bowel and bladder and she went to the bathroom when needed. She stated that the resident was not on a toileting program. She explained that the resident was ambulatory but unsteady and she was better off using a walker. NA #1 observed the walker folded against the wall and she indicated that she didn't know that the resident had been falling.

NA #5, assigned to Resident #16, was interviewed on 2/17/22 at 9:13 AM. NA #5 stated that Resident #16 was confused, high risk for falls

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and would not remember to follow instructions like to use the call light or call for assistance. She could ambulate but unsteady and she was mostly continent of bowel and bladder. She reported that the resident would go to the bathroom unassisted and had been falling. She added that the resident was not on a toileting schedule. NA #5 indicated the resident needed close supervision to prevent her from falling.

A follow interview was conducted with the RN Supervisor and the Support Nurse on 2/17/22 at 9:14 AM. They both stated that Resident #16 was high risk for falls, she was unsteady but would get up and walk. She would not remember to follow directions. She was not supposed to go to the bathroom unassisted, but she did it anyway. They both indicated that the resident needed close supervision, and frequent checks and they would suggest moving her close to the nurse's station and to involve her in activities. The RN Supervisor revealed that they had not tried putting the resident on a toileting schedule.

The MDS Nurse was interviewed on 2/17/22 at 2:15 PM. She stated that she started as MDS Nurse 4-5 months ago. She revealed that Resident #16 was high risk for falls, she was confused and would not remember to follow instructions. She could walk but unsteady. She was aware that some of her falls were from trying to use the bathroom. She added that taking her to the bathroom before and after meals and at bedtime might help in preventing her from falling but these had not been tried. She reported that using a walker would also help her from falling but there was no space in her room for the walker, it was folded and stored away from her. The MDS Nurse reviewed the resident's care plan

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F 689	Continued From page 111 for falls and verified that there was no new intervention added to the care plan after each fall. Nurse #4, assigned to Resident #16, was interviewed on 2/17/22 at 4:56 PM. The nurse stated that Resident #16 was confused and was high risk for falls. She was able to ambulate but unsteady. She had several falls trying to get up and walk unassisted. She had falls trying to go to the bathroom and she knew when she has to go. She reported that Resident #16 was not on a toileting program, but she thought that might help in preventing her from falling, however she didn't think the staff has the time to take her to the bathroom as scheduled. She reported that she saw her walking unassisted, and the staff could not watch her every minute. Resident #16's attending physician was unable to be reached for an interview. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that Resident #16 was high risk for falls. She reported that one day she saw her walking on the hallway unassisted. The DON indicated that big turn-over of direct care staff and administrative staff and change of roles had contributed to these concerns with falls. She indicated that the Support Nurse and the MDS Nurse were new to their roles.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		3/29/22

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F 692	Continued From page 112 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Medical Director, Registered Dietician and staff interviews, the facility failed to provide assistance with meals as ordered for a resident with weight loss (Resident #40) and failed to monitor a resident's weights as ordered and implement interventions for weight loss (Resident #52). This was for 2 of 5 residents reviewed for nutrition. The findings included: 1) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia, protein-calorie malnutrition, glaucoma, and dysphagia (difficulty swallowing). The active physician orders revealed an order dated 10/15/15 to provide assistance with meals and supplements every day and evening shifts.	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 1. For clinical services, a corrective action was obtained on 3/3/2022. Based on staff interviews, observations, and record review nutrition and hydration maintenance was not maintained for 2 of	

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F 692	Continued From page 113 Review of a Speech Therapy Discharge Summary dated 6/16/16 indicated Resident #40 would need ongoing prompting and redirection to continue to stay on task during meals. A Registered Dietician (RD) progress note dated 10/28/21 revealed weight loss was present with varying intake and staff provided assistance with meals. Resident #40's active care plan, last reviewed 12/2/21, included a focus area for "I have a nutritional problem related to receiving a mechanically altered diet and poor meal intakes. I have supplements and an appetite stimulant in place due to poor intakes. At times I may need assistance with meals or cueing.". The interventions included to let resident feed herself but assist with meals when needed as well as provide encouragement and cueing. A quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severely impaired cognition and required supervision/oversight/encouragement of a staff member for eating. She was coded with weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. A review of Resident #40's weight history was completed and revealed the following weights over a 6-month time period: - 8/6/21 was 124.1 pounds (lbs.) - 12/19/21 was 111 lbs. - 1/17/22 was 105.4 lbs. The weight history revealed Resident #40 had a 5.31 % weight loss in a month and 17.74 % weight loss in 6 months.	F 692	5 residents. For Resident #40 assistance at meals was not provided per orders and resident experienced significant weight loss. For Resident #40 meal assistance was reviewed and modified to total assist and up with all meals. Hospice was consulted for Resident #40 to liberalize diet and to review weights; weights to be obtained per Hospice guidance. For Resident #54 significant weight loss was not identified by clinical team nor were consults made to interdisciplinary team and therefore interventions were not implemented in a timely manner. For resident #54 weights were reviewed by clinical team; weekly weights implemented, Med Pass supplement initiated, and meal assistance modified to set up meals with clock. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/3/2022 in-service was completed with nursing, nursing assistants, and department heads. On 3/3/2022 all resident orders were reviewed to create a comprehensive list of residents that require assistance at meals and made available to staff via communication book. Meal tickets were also altered to highlight meal assistant requirements. By 3/11/2022 all staff employed to work AM/day shifts had completed the Feeding Program and were classified as	

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F 692	Continued From page 114 The February 2022 Medication Administration Record (MAR) indicated Nurse #2 had initialed assistance with meals/supplements had been provided on 2/14/22 and 2/15/22 day shift (7:00 AM to 3:00 PM). On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in her bed with the lunch tray in front of her. It was noted the silverware was still wrapped up in a napkin to the right side of the plate. Straws were in her cup of tea and juice and on a regular plate was butter beans, macaroni and cheese and a chopped-up meat. A cup of orange sherbet was opened and to the left side of the plate. Resident #40 was observed using her right-hand fingers to feed herself butter beans. She had consumed 25% of the meal at that time. Nurse Aide (NA) #2 was interviewed in the room of Resident #40 on 2/14/22 at 12:40 PM. She stated she was not assigned to care for Resident #40, was unsure who passed out the lunch tray, but was familiar with Resident #40. NA #2 unrolled the silverware and napkin and placed to the right side of the plate while Resident #40 continued to use her fingers to eat. She stated Resident #40 was independent with her meals, was unaware she required cueing or supervision with meals and left the room. A phone interview occurred with a family member of Resident #40 on 2/14/22 at 2:31 PM who stated when Resident #40 first came to the facility she was able to feed herself, but her vision and dementia had progressively gotten worse and she had started to use her fingers. The family member stated she would assist Resident #40 with meals when she visited and assumed the	F 692	competent to provide assistance at meals. On 3/7/2022 the dining room has been reopened; staff scheduled to dining room to ensure staff available for assistance at meals. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: • ADL's Eating Presentation • Tray Delivery and Set-up for Nursing/CNA Training • Nursing and Nursing Assistant Meal Procedures • Nutrition and Hydration Policies. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Manager or designee will monitor meal service 5 times weekly x 4 weeks, then weekly x 2 months, and then monthly x 3 months using the Quality Assurance Audit tool. Monitoring will include ensuring staff are using the proper channels to review which residents require assistance at meals, providing assistance with meals, and updating multiple channels to provide accurate	

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staff were doing the same. The family member added Resident #40 had always been a small eater never consuming more than 50% to 75% of meals even prior to admission to the facility.

On 2/15/22 at 12:15 PM, Resident #40 was observed sitting up in bed with the lunch tray in front of her. On the regular plate was chopped Salisbury steak and gravy, mashed potatoes, and peas. A container of orange sherbet sat to the left of the plate with water and tea. The silverware and napkin were unrolled and present to the right side of the plate. Resident #40 was observed eating peas with her fingers and stating, "they taste so good but their hot". NA #1 entered the room and scooped the peas on a spoon and placed where Resident #40 could get to it. Resident #40 then picked up the spoon and brought it to her mouth. NA #1 again scooped peas onto the spoon to which Resident #40 fed herself. NA #1 then left the room and Resident #40 returned to eating with her fingers.

NA #1 was interviewed on 2/15/22 at 12:20 PM, who was familiar with Resident #40. She stated she was unaware Resident #40 required assistance or cueing with her meals and that she "ate on her own. " When asked why she scooped peas onto the spoon, she stated "because you were watching her."

The DM was interviewed on 2/15/22 at 1:44 PM, who was familiar with the resident. She stated "in the past" staff had told her Resident #40 liked to "play" with her food and wouldn't allow staff to assist with meals. She recalled Resident #40 would go to the dining room for meals prior to COVID-19 and received cueing and oversight there but was unsure how much assistance staff

information regarding assistance at meals. The Dietary Manager or designee will monitor nutrition and hydration status via weight review weekly x 3 months, and then monthly x 3 months using the Quality Assurance Weight Review Audit. Weight change reviews will include insuring weights are obtained per policy and significant weight changes are addressed properly and timely to maintain nutrition and hydration status. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager

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provided now.

On 2/15/22 at 3:48 PM, NA #7 was interviewed. She explained she worked the second (3:00 PM to 11:00 PM) shift and was familiar with Resident #40. NA #7 stated at dinner she would provide Resident #40 with her tray, open all containers, and unroll silverware. Stated she would provide cues to eat with the silverware as she walked by the room and would often get a sandwich for the resident as she liked them and was less messy on her fingers. NA #7 stated she was unaware of the order to provide assistance with meals but tried to supervise anyway and denied Resident #40 refusing assistance.

Nurse #2 was interviewed on 2/16/22 at 11:02 AM. She had indicated assistance was provided with meals during the first shift on 2/14/22 and 2/15/22. Nurse #2 explained Resident #40 fed herself after staff provided set up of the tray and often used her fingers. Stated Resident #40 refused assistance and she thought the NAs were providing cueing with meals which is the reason she had signed off on the MAR as completed for 2/14/22 and 2/15/22.

An observation was made of Resident #40 being assisted with her lunch meal on 2/16/22 at 12:15 PM by Nurse #2. The resident was readily accepting food from a spoon and kept stating how good it tasted.

An interview was conducted with NA #4 on 2/16/22 at 2:00 PM who was familiar with Resident #40. She explained she was an agency staff member, had been assisting the facility since November 2021 and worked both the first and second shifts. NA #4 explained when she

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provided meals to Resident #40, she would open containers, made sure everything was in place and then checked on her frequently when she walked by the room. NA #4 was unaware Resident #40 had an order to assist with meals.

A phone interview occurred with the RD on 2/17/22 at 5:10 PM. She stated she assessed Resident #40 every month and was aware of her weight loss over the past 6 months. She felt it was due to the natural decline of the disease process and was unaware the staff were not assisting with meals as ordered.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, and stated she was unaware Resident #40 was not receiving consistent assistance with her meals, to include cueing or physical assistance, but she expected her to be assisted as needed and ordered.
2. Resident # 52 was admitted on 1/6/21 with cumulative diagnoses of breast cancer and Alzheimer's Disease.

There was no documented evidence of any Registered Dietician (RD) note since 1/18/21 on Resident #52.

Review of Resident #52's nutrition care plan last revised on 5/6/21 read she was receiving a therapeutic, mechanically altered diet and had experienced weight loss. Interventions included observation/record/report to Medical Director (MD) any significant weight loss of greater than 10% over 6 months. The Registered Dietitian (RD) was to evaluate and make diet change recommendations as needed.

Review of Resident #52' weight's revealed the

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facility was not following the MD order dated 4/14/21 for weekly weights.

Review of a weight change note written by the Dietary Manager (DM) dated 6/7/21 at 12:10 PM read Resident #52 was 185.0 pounds. There were no weight change notes until the DM wrote a weight change note dated 10/8/21 at 11:10 AM which read Resident #52's weight was 166.4 pounds. The note was read to continue her weekly weights.

Review of a weight change note written by the DM dated 11/8/21 at 11:01 AM read Resident #52's weight was 164.8 pounds. The note read that her weight was stable and to continue monthly weights.

There was no documented evidence of a weight for December 2021.

Resident #52's weight on 7/7/21 was 183.6 pounds. Her weight on 1/17/22 (6 months) was 163.0 pounds. The calculated percentage lost in 6 months was 11.22% weight loss.

Review of a ST evaluation and Plan of Treatment dated 12/7/21 read Resident #52 was picked up for ST services due to her swallowing dysfunction and visitors bringing in foods which were not currently recommended. Staff report that Resident #52 was consuming thin liquids and regular food safely and with evidence of aspiration.

Resident #52's 5-day Minimum Data Set (MDS) dated 1/25/22 indicated severe cognitive impairment, no behaviors, independent with

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eating, a weight of 163 pounds and she was not coded for any weight loss.

Her weight on 2/7/22 was 162 pounds.

Review of a ST treatment note dated 2/8/22 read Resident #52 required maximum cues due to her decreased cognitive skills. She required repetition to complete task.

Review of Resident #52' February 2022 Physician orders included an orders follows:
-Order dated 1/6/21 for a daily chemotherapy medication (Femara) to be administrated twice daily to treat her breast cancer.
-Order dated 4/14/21 for weekly weights dated 4/14/21
-Order dated 12/7/21 for speech therapy (ST) for a potential diet upgrade
-Order dated 2/15/22 for 120 milliliters of no sugar added fortified shake three times daily

A review of an undated electronic Kardex or care guide for the aides it should be reported to the nurse for intake of less than 25% or any meal refusals.

Review of Resident #52's meal consumption percentages from November 2021 to 2/16/22 multiple meal refusals and multiple occasions where she only ate 25% of her meals.

An observation was conducted on 2/14/22 at 12:30 PM of resident #52. She was lying in bed with the head of her bed raised approximately 30 degrees. In front of her was her bedside table was her lunch tray. She had apparently eaten a bite of her minced chicken and spit it out. Resident #52 stated she was a slow eater and

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able to feed herself. Nursing Assistant (NA) #4 entered the room and repositioned Resident #52 in bed and raise the head of her bed up to approximately 45 degrees. NA #4 stated Resident #52 was able to feed herself but it took a long time.

An observation was conducted on 2/15/22 at 12:10 PM. Resident #54 was sitting in the bed upright with her lunch tray positioned in front of her. NA #2 was setting up her tray and stated Resident #52 was able to feed herself.

An interview was conducted on 2/15/22 at 12:20 PM with the DM. She stated the RD came monthly or more often if needed. She stated she reviewed the weekly and monthly weights and if something looked off, she would ask the staff to obtain a reweight. She stated she was under the impression that Resident #52' weight loss was expected due to her diagnosis of cancer. The DM stated Resident #52 should be up out of bed to eat meals but the staff were not getting her up. The DM stated nursing management was aware of the issue for not getting her up out of bed for meals.

An interview was conducted on 2/15/22 at 1:40 PM with NA #2. She stated Resident #52 ate 25% of her lunch. She stated she had not reported her intake to the nurse but she would prior to leaving.

An interview was conducted on 2/15/22 at 4:10 Pm with Nurse #3. She stated the aide did not report Resident #5'2 meal intake of 25%.

An observation was conducted on 2/16/22 at 12:25 PM. Resident #52 was sitting in the bed

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upright with her lunch tray positioned in front of her. There was a sugar free fortified shake was on her tray open with a straw in it. She stated she had not tried her shake but would get to it.

An interview was conducted on 2/16/22 at 1:54 PM with NA #4. She stated she put Resident #52's dentures in today for lunch but they no longer fit due to her weight loss. She stated Resident #52 ate approximately 25% of her lunch and approximately half of the sugar free fortified shake. She stated she did not report Resident #52' meal intake since she drank half of her fortified shake. NA #4 stated she offered to get Resident #52 up out of bed at breakfast and lunch but the resident refused. NA #4 stated when visitors came, Resident #52 was able to tolerate regular food but the ST said no change in her diet at present.

An observation was conducted on 2/17/22 at 8:54 AM. Resident #52 was out of bed sitting in her wheelchair. She stated it felt good be up out of bed. She had eaten approximately 50% of breakfast and drank 100% of her sugar free fortified shake.

An interview was conducted on 2/17/22 at 11:12 AM with the Speech Therapist (ST). The ST stated she was not working with Resident #52 for weight loss and that would be the RD's responsibility. She stated she picked up Resident #52 in December because her family was bringing in food from outside and the staff had mentioned that maybe she could tolerate a diet upgrade. The ST stated she had only upgraded her liquids but not her meal texture. The ST stated she recommended that the staff have her up out of bed for all her meals and offer cueing

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but sometimes she refuses to get up out of bed. The ST confirmed that Resident #52' new dentures apparently cause her discomfort but they were a new pair.

An telephone interview was conducted on 2/17/22 at 5:15 PM with the RD. She stated Resident #52's weight's flagged as an issues on 1/31/22 but her weights appeared stable from September 2021 to January 2022. Resident #52's weight on 2/7/22 was 162 pounds. She confirmed Resident #52 was having continued weight loss. The RD stated she was new to the facility and started in July 2021. She stated when she started, Resident #52 was not on her caseload. The RD was unable to answer why she was not addressed Resident #52's weight loss in September 2021 when Resident #52 went from 183.6 pounds on 8/6/21 down to 166.4 on 9/13/21. A reweight 9/23/21 and Resident #52 was 167.6 pounds. The RD stated normally the DM reviewed the weekly or monthly weights and would let her know who needed to be seen on her next visit to the facility. She stated she was under the impression that Resident #52's weight loss was unavoidable due to cancer.

An telephone interview was conducted on 2/17/22 at 4:56 PM with the MD. He stated apparently Resident #52 never flagged for weight loss. He stated the fact the Resident #52 has a diagnosis of cancer did not mean she was terminal. The MD stated she was being treated daily with a chemotherapy medication and she would not be on the medication if she were terminal. The MD stated he was not aware that a order for weekly weight was not being followed. When informed that Resident #52 was not on any appetite stimulant and a dietary nutritional supplement

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F 692	Continued From page 123 was not started until 2/15/22, he stated her weight loss needed to be addressed and additional interventions put in place. An interview was conducted on 2/17/22 at 6:00 PM with the DON. She stated the facility should have acted on her significant weight loss, continued weight loss and implanted interventions. The DON was unable to answer why this was not done.	F 692		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility administration failed to provide effective oversight to ensure the call system was fully operational. The auditory feature of the call system has been nonfunctional since 8/14/21. This deficient practice affected all residents residing at the facility. This citation is cross referred to F919-F: Based on observations, staff and resident interviews and record review, the facility failed to have a fully functioning call system with no audio feature to assist with the staff with answering resident call lights on 3 of 3 halls. This deficient practice has been ongoing since 8/14/21. The findings included:	F 835	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. To correct the defective call-system, the facility placed hand bells in each resident's room on 02/17/2022. Hand bells will serve as auditory part of call	3/29/22

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F 835	Continued From page 124 An interview was conducted on 2/17/22 at 10:35 AM with the interim Administrator. He stated he started at the facility early December 2021 and noted the call system was not fully functional at that time. He asked the facility Maintenance Supervisor (MS) to follow up on the replacement status. He stated he reached out on 2/14/22 to the corporate MS to inquire the status of the call system replacement and was told the earlier the replacement would be April 2022. A telephone interview was conducted on 2/17/22 at 3:09 PM with the corporate MS. He stated he had been assisting the facility MS in getting the needed replacement. He stated the quote was approved on 12/2/21 but the call system selected could not provide an actual date of the replacement at that time. He instructed the facility MS to reach out to the selected call system provider on 2/16/22 and the soonest they can replaced the call system was 4/25/22 due to their staff being out with COVID and the increased housing in the Lee County area.	F 835	system until installation of the new nurse call system. Additionally, all residents will be rounded on by nursing staff hourly beginning 03/04/2022. 2. Vendor has been identified (Modern Systems) to install new nurse call system with tentative installation date of 4/25/2022. The Department of Health Service Regulation, division of construction, must approve the design of nurse call system. This date my change as a result. 3. On 3/11/2022, the Regional Director of Operations educated the Inter-disciplinary Team (IDT) on need to initiate immediate use of hand-bells and hourly rounding at any point the nurse call system is non-functional. 4. IDT will review nurse call system monthly beginning 04/01/2022 with initial use of hand bell system and hourly rounding. Audits will continue until 7/1/2022 or until automated system has been in place for 2 months.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		3/29/22

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F 842	Continued From page 125 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 126 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have complete and accurate medical records in the area of wound care (Residents #17 and #26), protective skin coverings (Resident #40), medications and topical treatments (Resident #40). This was for 3 of 22 residents reviewed. The findings included: 1) Resident #17 was originally admitted to the facility on 3/1/21 with a recent readmission on 1/28/22. She had multiple diagnoses that included osteomyelitis (inflammation of the bone caused by an infection) of the vertebra and sacral region and pressure ulcer of the sacral region. A quarterly Minimum Data Set (MDS) assessment dated 12/11/21 indicated Resident #17 was cognitively intact and had 1 stage 3 (a sore that extends into the tissue beneath the skin forming a crater) pressure ulcer.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 The facility failed to have complete and accurate medical records in the area of wound care. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/22/2022 the wound nurse assessed the sacral wound for resident # 17. with no observed changes to areas of ordered treatment and provided and documented the treatment as ordered.	

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F 842	Continued From page 127 The physician orders noted an order dated 2/8/22 to cleanse the sacral area with wound cleanser, apply Aquacel (a dressing that forms a gel on contact with wound fluid to promote healing), cover with dressing twice a day. A review of the February 2022 Treatment Administration Record (TAR) revealed no wound care had been signed off as completed to Resident #17's sacral wound, on 2/8/22, 2/9/22 and 2/10/22 on the evening (3:00 PM to 11:00 PM) shift. On 2/16/22 at 3:29 PM, Nurse #1 was interviewed. She was assigned to Resident #17 on 2/8/22, 2/9/22 and 2/10/22 on the evening shift. Nurse #1 reviewed the February 2022 TAR and confirmed she had not signed off Resident #17's sacral wound treatment had been completed. Nurse #1 stated she was certain the treatment occurred as ordered but forgot to initial the TAR. The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM and indicated she had started employment at the facility in January 2022. The DON stated it was her expectation Resident #40's TAR to be complete and accurate in regard to her wound care. 2a) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and osteoarthritis. The physician orders revealed an order dated 3/26/20 to apply geri-sleeves (protective sleeves) to both hands/arms every shift for skin integrity.	F 842	On 2/22/2022 the Director of Nursing and RN Supervisor assessed pressure ulcers to the right and left ischium and right trochanter for resident #26 with no observed changes to areas of ordered treatment and provided and documented the treatments as ordered. On 2/18/2022 the RN supervisor assessed both arms and hands for resident # 40 with no observed changes and the bilateral geri sleeves were applied. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents are potentially at risk for the deficient practice. On 3/9/2022 the Director of Nurses, Wound Nurse, Registered Nurse Supervisor (RN), initiated an audit of 100% of resident treatments for the last 7 days for all current residents. The audit consisted of a review of the Electronic Medical Administration Records notes to identify any treatments that were not documented as completed. On 3/9/2022, the Director of Nurses notified the Medical Director and Responsible Parties of the treatments that were not administered and the steps that will be taken to prevent future occurrences. Results: 30 of 57 residents were in compliance for documentation of completed treatments and no other issues with documentation or application of geri sleeves was found. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 842	Continued From page 128 The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and was coded with skin tears present. A review of the February 2022 Treatment Administration Record (TAR) revealed the geri-sleeves were signed as being on Resident #40 on 2/14/22, 2/15/22 and 2/16/22 day shift (7:00 AM to 3:00 PM) by Nurse #2. Resident #40 was observed on 2/14/22 at 11:30 AM, while lying in bed with her eyes closed. Her arms were laying on top of the covers without any protective sleeves. On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in bed eating lunch. There were no protective sleeves present to her arms/hands. Resident #40 was observed on 2/15/22 at 10:42 AM sitting up in her bed. She was dressed in a hospital gown without any protective sleeving to her arms/hands. Another observation was made of Resident #40 on 2/15/22 at 12:15 PM with no protective sleeves present to her arms/hands. On 2/15/22 at 1:19 PM, Resident #40 was observed lying in bed with her eyes closed. There were no protective sleeving on her arms/hands. Resident #40 was observed on 2/16/22 at 10:22 AM, dressed in a hospital gown without protective sleeving to her arms/hands. Nurse #2 was interviewed on 2/16/22 at 11:02	F 842	Beginning on 3/09/2022 the Director of Nurses, Nurse Consultant and RN Supervisor began in-service education to all full time, part time, as needed and agency nurses • The learner will understand the importance of ensuring that treatments are administered as ordered by the Physician. • Confirming that treatment orders are documented following completion of the ordered treatment. • Notification of the MD/RP of any missed or refused treatments. • Treatment error process. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Nursing Leadership Team will monitor treatment documentation as part of Daily Clinical, Monday through Friday, to review EMAR progress notes. The audit will include review of the EMAR progress notes to identify any residents who have	

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AM. She reviewed the February 2022 TAR where she had marked Resident #40 had geri-sleeves present to her arms/hands on 2/14/22, 2/15/22 and 2/16/22. She stated she "had assumed they were on" when she marked them on the TAR and had not verified they were on. An observation was made of Resident #40 with Nurse #2, who confirmed they were not in place.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The DON's expectation was for Resident #40's TAR to be accurate regarding the geri-sleeves with nurses verifying they are in place before documenting so.

2b) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and anxiety disorder.

The physician orders revealed an order dated 4/21/21 for Lorazepam (a medication used to treat anxiety) 1 milligram (mg) one tablet by mouth every morning and at bedtime for anxiety.

The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and used an antianxiety medication 7 days.

A review of the February 2022 Medication Administration Record (MAR) revealed Lorazepam 1mg was not signed out as given or refused by Resident #40 for the bedtime dose on 2/5/22, 2/6/22 or 2/9/22.

A review of Resident #40's Narcotic Count Sheet

treatments that have not been documented as administered.

The Director of Nurses, or designee will monitor compliance utilizing the F 842 Treatment Audit Tool weekly x 2 weeks then monthly x 3 months or until resolved. The audit will review EMAR progress notes for a random 7 day period to identify any residents that have treatments that have not been documented as administered. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager.

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for Lorazepam occurred which revealed she had received the bedtime dose of Lorazepam on 2/5/22, 2/6/22 and 2/9/22.

On 2/16/22 at 3:29 PM, an interview occurred with Nurse #1, who was assigned to Resident #40 on the evening shift (3:00 PM to 11:00 PM) on 2/9/22. She reviewed the February 2022 MAR and confirmed the dose of Ativan 1mg at bedtime was neither marked as given or refused by the resident as well as Resident #40's Lorazepam Narcotic Count Sheet. Nurse #1 stated she provided the medication as ordered but forgot to sign on the MAR.

A phone interview occurred with Nurse #5 on 2/16/22 at 4:10 PM. She was assigned to Resident #40 on 2/5/22 and 2/6/22 on the evening shift. After reviewing the February 2022 MAR with her, she stated she always provided Resident #40's medications to her and just forgot to sign it on the MAR.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The DON stated it was her expectation for the MAR's to be complete and accurate.

2c) Resident #40 was admitted to the facility on 6/7/15 with diagnoses that included dementia and osteoarthritis.

The active physician orders revealed an order dated 5/20/20 for Ketoconazole Shampoo (an antifungal shampoo) 2% to be applied to the scalp topically every evening shift on Monday and Thursday for tinea versicolor (a common fungus).

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Use on the scalp and hair and rinse well on shower days.

The quarterly Minimum Data Set (MDS) assessment dated 1/28/22 indicated Resident #40 had severe cognitive impairment and required extensive assistance with personal hygiene and bathing.

Resident #40's room history was reviewed and indicated she had been in the same room since 7/2/21 with a scheduled shower/shampoo on Tuesday and Friday during the day shift (7:00 AM to 3:00 PM). She had a short stay in a different room on the same hallway from 1/25/22 to 2/9/22 with the shower/shampoo scheduled on Wednesday and Saturday during the day shift.

A review of the February 2022 Medication Administration Record (MAR) revealed the Ketoconazole shampoo was signed as provided to Resident #40 on Monday and Thursdays as ordered (2/3/22, 2/7/22 and 2/14/22).

Nurse #1 was interviewed on 2/15/22 at 3:54 PM, who had signed the February 2022 MAR, that Resident #40 received Ketoconazole shampoo on 2/14/22. The nurse stated she had assumed it was done by the Nurse Aide (NA) because they didn't tell her it wasn't done. Nurse #1 added she had not verified the shampoo had been provided as ordered.

On 2/16/22 at 8:30 AM, an interview occurred with Nurse #3. She had signed off on the February 2022 MAR that Resident #40 received Ketoconazole shampoo on 2/3/22 and 2/7/22. Nurse #3 stated she didn't verify with the NA that the shampoo had occurred but had assumed it

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had since the NA had not told her otherwise.

NA #4 was interviewed on 2/16/22 at 2:00 PM and worked at the facility since November 2021 and worked both the 7:00 AM to 3:00 PM (first) and 3:00 PM to 11:00 PM (second) shifts. NA #4 was familiar with Resident #40 and was often assigned to care for her when she worked. NA #4 was unaware Resident #40 required to be shampooed with Ketoconazole.

On 2/17/22 at 9:35 AM, NA #1 was interviewed and stated she worked both the first and second shifts and was often assigned to Resident #40 when she worked. NA #1 was unaware Resident #40 required Ketoconazole shampoo.

A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM, who had been assigned to Resident #40 on the second shift of 2/14/22. She stated Resident #40 was scheduled for showers/shampoos on the first shift, so she had not provided one to her on 2/14/22. NA #12 added she was unaware Resident #40 was to be shampooed with Ketoconazole.

The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. The DON stated it was her expectation for the MAR to be documented accurately by the nursing staff.
3. Resident #26 was admitted on 3/5/21.

Review of Resident #26 ' s quarterly Minimum Data Set (MDS) dated 1/2/22 indicated he was cognitively intact and coded for rejection of care. He was coded for three pressure ulcers.

Review of Resident #26 ' s Treatment

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Administration Records (TAR) for January and February 2022 revealed multiple omissions on 1/18/22, 1/20/22, 1/21/22, 2/5/22, 2/6/22, 2/9/22 and 2/10/22.

Review of Resident #26 ' s February 2022 Physician orders included treatment orders for his pressure ulcers.

Resident #26 ' s pressure ulcer care plan revised on 12/16/21 read he was to receive his treatments as ordered. Resident #26 was also care planned refusal of wound care and assessment.

An interview was conducted on 2/14/22 at 10:44 AM with Resident #26. He stated the facility was not providing his treatments as ordered and that he was doing his treatment on occasion himself.

An interview was conducted on 2/14/22 at 2:00 PM with the facility Wound Nurse. She stated Resident #26 went to the wound clinic at the hospital monthly for a wound evaluation. She stated Resident #26 was noncompliant with his wound care and recommendations. She stated she would not initial the TAR until she knew if Resident #26 was going to refuse his wound care so she could try to convince him to allow his wound care. She stated she sometimes forgot to initial off on the TAR or indicted on the TAR his refusals.

An interview was conducted on 2/17/22 at 9:30 AM with Nurse #4. She stated worked on weekends occasionally and would assist with treatments. Nurse #4 stated Resident #26 was noncompliant with his wound treatments. She stated she sometimes forgot to document his

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F 842	Continued From page 134 refusals on the TAR. An interview was conducted on 2/17/22 at 6:00 PM with the DON. She indicated she had started employment at the facility in January 2022. The DON stated it was her expectation Resident #26 ' s TAR to be complete and accurate in regard to his wound care. The DON also expected Resident #26 ' s refusals of wound care to be documented in his medical record.	F 842		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and	F 886		3/29/22

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F 886	Continued From page 135 (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Nurse Consultant and staff interview, the facility failed to follow physician's order and facility's policy by not	F 886	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 886	Continued From page 136 placing a resident who had refused COVID-19 testing on enhanced precaution during an outbreak for 1 of 1 sampled resident reviewed (Resident #14). The failure occurred during a coronavirus pandemic. Findings included: The facility's policy on COVID-19 testing dated 2/2022 was reviewed. The policy indicated in part "If a resident is asymptomatic and declines testing at the time of facility wide testing, decision on placing the resident on Transmission Based Precautions for COVID-19 or providing usual care should be based on whether the facility has evidence suggesting SARS-CoV-2 transmission (i.e, confirmed infection in healthcare personnel (HCP) or nursing home onset infection in a resident)". Resident #14 was admitted to the facility on 9/4/17 with multiple diagnoses including developmental disorder that affects communication and behavior. Resident #14's care plan with the revision date of 2/4/22 was reviewed. The care plan problem was "I am on Enhanced Droplet Precaution: I refused COVID testing". The goal was "I will be free of symptoms of highly contagious respiratory infection". The approaches included Enhanced droplet precaution: staff should don eye protection (goggles), mask, gown and gloves prior to entry, hand hygiene should be performed upon entering the room and after personal protective equipment (PPE) is removed and use as much disposable equipment as possible or use dedicated equipment as thermometer and blood pressure cuff".	F 886	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F886 The facility failed to follow a physician order and facility policy by not placing a resident who had refused Covid 19 testing on enhanced precautions during an outbreak. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/15/2022 the Infection Control Preventionist placed an isolation sign for Enhanced Droplet Precautions on Resident #14□s door and an isolation cart with the appropriate Personal Protective Equipment outside of the room. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Any resident who refuses testing during a Covid 19 outbreak or any resident who has orders for Enhanced Droplet Precautions could be affected. On 2/15/2022 the Director of Nurses/Infection Control Preventionist audited all resident rooms with orders for Enhanced Droplet Precautions to assure isolation signage was in place with no other identified residents without appropriate isolation signs in place. All residents who had refused testing had	

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F 886	Continued From page 137 Resident #14 had a doctor's order dated 2/4/22 for enhanced precaution due to refusal for COVID testing. On 2/14/22 at 10:01 AM and 4:02 PM, Resident #14 was observed in his room. He was residing in a private room. There was no isolation sign noted on his door nor isolation cart outside his room. Nurse Aide (NA) #1, assigned to Resident #14, was interviewed on 2/15/22 at 9:05 AM. She stated that Resident #14 was not on any isolation. The Infection Control Preventionist (ICP) was interviewed on 2/15/22 at 9:15 AM. The ICP reported that Resident #14 was not on isolation. When asked to check the doctor's order, she reported and verified that Resident #14 had a doctor's order dated 2/4/21 for enhanced precaution due to refusal for COVID testing. The ICP was observed to put enhanced precaution sign on the residents' door and isolation cart outside the resident's room. A follow up interview was conducted with the ICP on 2/15/22 at 9:30 AM. She explained that she started as ICP in October 2021. She was aware that Resident #14 had been refusing COVID testing since end of January 2021, but she was not aware that there was an order to place him on quarantine. She added that she was not aware of the facility's policy to quarantine the resident if he/she was refusing testing during the outbreak. The Nurse Consultant was interviewed on 2/16/22 at 12:05 PM. The Nurse Consultant provided the facility's policy dated 2/2022 on	F 886	Enhanced Droplet Precaution signs on the door and an isolation cart with the appropriate PPE outside of the room. On 2/15/2022 the Nurse Consultant educated the Director of Nurses and the Infection Control Preventionist on facility policy related to Covid 19 program and testing, resident refusal of testing during a Covid 19 outbreak and placing residents on enhanced droplet precautions per physician order and supplying an isolation cart with appropriate PPE outside of the resident□s door. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/09/2022 Director of Nurses, Nurse Consultant and the Nurse Manager began education to all full time, part time, PRN and agency Nurses and CNA□s on the following: " Covid 19 Testing Policy " Refusal of testing by a resident during an outbreak isolation practices This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.	

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F 886	Continued From page 138 COVID 19 testing. She verified that if a resident was refusing COVID testing during the outbreak, the resident was placed on enhanced precaution until the end of the outbreak. She reported that the facility had been on outbreak since 12/25/21. The Minimum Data Set (MDS) Nurse was interviewed on 2/17/22 at 2:50 PM. She verified that she had transcribed the order and initiated the care plan for enhanced precaution on 2/4/22 for Resident #14. She had notified the nurse (unable to remember name) of the new order for enhanced precaution. The Director of Nursing (DON) was interviewed on 2/17/2 at 3:34 PM. She reported that she just started as DON of the facility in January 2022. She stated that she expected the facility's policy and the doctor's order to be followed regarding placing the resident on quarantine to prevent the spread of infection. The DON indicated that lack of communication and big turn-over of staff contributed to this failure of not following doctor's order and facility's policy.	F 886	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses or Infection Control Preventionist will monitor compliance utilizing the F886 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing or Infection Control Preventionist will monitor compliance with facility policy for Covid 19 testing for those residents who refuse testing during a Covid 19 outbreak. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919		3/29/22

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F 919	Continued From page 139 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to have a fully functioning call system with no audio feature to assist with the staff with answering resident call lights on 3 of 3 halls. This deficient practice has been ongoing since 8/14/21. The findings included: During initial tour on 2/14/22 at 9:30 AM, it was noted that the call lights were lit above the resident door but there was no audio sound heard at the one centralized nursing station or outside the resident rooms. The facility Maintenance Supervisor (MS) provided an email dated 8/14/21 at 8:18 PM that he sent to the corporate (MS). The email read lightning struck and knocked out the power at the facility. The generator came on and the power was restored but phone lines remained down expect for line 2 that could be used to make calls until the phone provider repaired the issues. The response from the corporate MS was to let him know if there was anything else, he could do. There was no mention of the call lights not functioning properly in this email. The facility Maintenance Supervisor (MS) provided an email dated 8/30/21 at 12:13 PM sent by the corporate MS to another corporate contact that read a call system provider came on Saturday 8/28/21 to assess the call system. It was determined that the current call system was unserviceable due to the age of the system and a lack of parts. A copy of the quote was provided by the facility MS was dated 9/7/21 completed by	F 919	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. To correct the defective call-system, the facility placed hand bells in each resident's room on 02/17/2022. Hand bells will serve as auditory part of call system until installation of the new nurse call system. Additionally, all residents will be rounded on by nursing staff hourly beginning 03/04/2022. 2. Vendor has been identified (Modern Systems) to install new nurse call system with tentative installation date of 4/25/2022. The Department of Health Service Regulation, division of construction, must approve the design of nurse call system. This date my change as a result. 3. On 3/11/2022, the Regional Director of Operations educated the Inter-disciplinary Team (IDT) on need to initiate immediate use of hand-bells and hourly rounding at any point the nurse call system is non-functional. 4. IDT will review nurse call system	

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F 919	Continued From page 140 this call system provider. The facility MS provided a copy of a service worksheet dated 10/26/21 completed by a different call system provider. The worksheet indicated the call system would need to replaced, upgraded and a staff person would follow up with a quote. The facility MS provided a copy of an email dated 12/2/21 from the facility MS asking the second service provider about the status of the quote promised after the 10/26/21 service call. The facility MS provided a copy of the second call system provider's quote dated 12/2/21. The Administrator provided a copy of an email dated 2/14/22 from the selected call system service provider addressed to the corporate MS read the earliest the system could be replaced would be 4/25/22. An observation was conducted on 2/14/22 at 10:44 AM room number 111. Resident #26 was residing in the room. The call light system was activated in the room and in the bathroom but there was no audible sound. Outside and above the resident door was observed a white flashing light from activating the call light in his room and a red flashing light from activating his bathroom call light. An interview was conducted on 2/14/22 at 10:57 AM with Nurse #2. She stated lightening knocked out the call system and it had not been repaired yet. She stated there was only one nurses station with all three halls were visible from it. Nurse #2 stated was not difficult to see who's call light was lit and needed assistance. Nurse #2 stated at the	F 919	monthly beginning 04/01/2022 with initial use of hand bell system and hourly rounding. Audits will continue until 7/1/2022 or until automated system has been in place for 2 months.	

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time that the audio feature of the call system went down in August 2021, the aides have been making hall rounds every 10 minutes and to her knowledge, that appeared to be working.

During an observation on 2/16/22 at 11:00 AM, Resident #26's call light was observed on. There was no audible sound. At 12:18 PM, Nursing Assistant (NA) #5 was observed answering his call light.

An interview was conducted on 2/16/22 at 12:20 PM with NA #5. She stated she was aware that some residents were upset over long waits for responses to call lights. She stated she tried to round on her halls every 10 minutes or so but during meals and morning ADLs, she was unable to ensure call lights were always answered timely. She stated there was only one nurses station and all the halls could been seen from the nurses station. NA #5 stated the call light system lost the audio feature sometime last summer and that management was aware.

An observation was conducted on 2/14/22 at 11:06 AM of room number 308. Resident #29 was residing in this room. After pushing his call light, NA #4 responded within 5 minutes. There was a visible white light above his door but there was no audible sound. His bathroom call light was activated with a red flashing light observed outside his door but there was no audible sound heard.

An interview was conducted on 2/14/22 at 1:00 PM with NA #4. She stated she was an agency aide and had been working at the facility since November 2021. She stated the call light system has never made an audible sound and staff would

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need to be at the nurses station or on the 300 hall to observe the light above a resident's door. She stated she had been told to round on her assigned hall every 10 minutes. She stated management was aware of the problem to her knowledge.

An observation was conducted on 2/14/22 at 11:06 AM of room number 201. Resident #31 was residing in this room. His call light was engaged in his room and bathroom. Outside and above the resident door was a white flashing light from activating the call light in his room and a red flashing light from activating his bathroom call light.

An interview was conducted on 2/14/22 at 1:00 PM with NA #4. She stated she was an agency aide and had been working at the facility since November 2021. She stated the call light system has never made an audible sound and staff would need to be at the nurses station or on the 200 hall to observe the light above a resident's door. She stated she had been told to round on her assigned hall every 10 minutes. She stated management was aware of the problem to her knowledge.

An observation conducted on 2/16/22 at 8:30 AM of room 305. Resident #4 was residing in this room. He engaged his call light Outside and above the resident door was a white flashing light. The was no audible sound. NA #1 answered his call light at 9:10 AM.

An interview was conducted on 2/16/22 at 9:12 AM with NA #1. She stated the aides were supposed to walk up and down their assigned hall every 10 minutes but sometimes there was a

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delay during meals, morning ADLs and shift change.

An interview was conducted on 2/16/22 at 10:30 AM with the facility Support Nurse. She stated she had been at the facility for a very long time and most of the department heads and management had been recently replaced and only a few nurses and aides would have been employed August 2021. The Support Nurse stated she was working at the time the lightning struck knocking the out the audio portion of the call system and the previous Administrator instructed the staff to round the halls every 10 minutes. She stated bells were not given out, but the previous Administrator directed the nursing staff to make hall rounds every 10 minutes. She recalled the rationale for not giving each resident a bell was because a lot of the residents were not able to use a bell.

An observation on 2/16/22 3:25 PM, the Registered Nurse (RN) Supervisor was putting a bell in each resident' room and instructed the resident to use the bell if staff did not respond prompt enough.

An interview was conducted on 2/16/22 at 4:41 PM with the RN Supervisor. She stated she had worked at the facility in the past but had recently returned about a month ago. She stated she was uncertain when the call system stopped the audio prompt, but the Administrator instructed her to pass out bells to each resident.

An interview was conducted on 2/17/22 at 9:30 AM with Nurse #4. She stated the sound portion of the call system had been out for a while, but the visual signal was still functioning properly.

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She stated none of her residents had complained about their call light's not making any sound. She stated she could see all three halls from the nurses station and the aides were making rounds every 10 minutes. Nurse #4 stated bells were given out yesterday as an extra measure.

An interview was conducted on 2/17/22 at 10:09 AM with the facility MS. He stated he recalled the Support Nurse calling him sometime in mid-August stating lightning struck the phone lines, but the generator had started. He stated he went to the facility right after the call to assess the problem and everything came back on except for the audio portion of the call system. He stated he contacted his corporate MS that same evening via email. The facility MS stated he understood there was a device that looked like a telephone that would give an audible alert at the nurses station. He stated the staff were instructed to round on each of the three halls every 10 minutes. He was instructed by the corporate MS to obtain the call system provider to assess the system and give the facility a quote on 8/28/21. The first quote was provided on 9/7/21 and he sent it to the corporate MS. He stated he was instructed to obtain another quote with a different call system provider. The facility MS stated he contacted another provider with the soonest availability of 10/26/21. He stated from that point on, he thought the corporate office was still reviewing the quotes. He stated it wasn't till 12/2/21 with the interim Administrator arrived that he realized he had not received the second quote from the 10/26/21 provider visit. He stated he called and emailed the provider on 12/2/21 and received their quote on 12/2/21 and he forwarded the quote to his corporate supervisor. He stated both call system providers recommended

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replacing the entire call system and the selected call system provider were to contact him with a date for the replacement. He stated he must have never received the call and forgot to inquire about the replacement date until yesterday.

An observation was conducted at the nurses station on 2/17/22 at 10:25 AM with the facility MS. A tan colored device that appeared to look like a regular telephone was grounded at the nurses station with a green colored cable. The device had 10 digits and display like a regular telephone. A call light was activated in a resident room. The call light was visible from the nurses station.

An interview was conducted on 2/17/22 at 10:35 AM with the interim Administrator. He stated since the facility only had one nurses station and all three halls were visible from the nurses station, resident's call lights were being answered without prolonged delays. He confirmed there was ample staff working at the facility and had a low resident census. The interim Administrator stated it was not difficult for the staff to walk a hall every 10 minutes or see a call light from the nurses station. He stated he asked the RN Supervisor to pass out the bells to the residents with instruction to ring the bell if not prompt response to the call light. He stated he asked the RN Supervisor to pass out bells on 2/16/22 when he discovered the call system would not be replaced until April 2022. The Administrator stated not all the residents could use a bell and the staff were instructed to continue to complete 10-minute rounds on the halls.

A telephone interview was conducted on 2/17/22 at 3:09 PM with the corporate MS. He stated he

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F 919	Continued From page 146 had been assisting the facility MS to get needed replacement. He stated the first delays were due to call system providers having no availability to come and give a quote sooner than they did. The corporate MS stated both quotes recommended replacement of the call system. He stated the quote was approved on 12/2/21 but the call system selected could not provide an actual date of the replacement. He instructed the facility MS to reach out to the provider on 2/16/22 and the soonest they can replace the call system was 4/25/22 due to their staff being out with COVID and the increased housing in the Lee County area. He stated he recommended that the facility pass out the bells at the time the problem happened but apparently the previous Administration opted to make hall rounds every 10 minutes.	F 919		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		3/18/22

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F 947	Continued From page 147 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Nursing Assistants (NAs) with annual dementia training for 4 of 5 sampled Nurse Aides reviewed for required in-service training (NAs #6, #7, #8 and #9). The findings included: NA #6's date of hire was 4/13/17. Review of in-service records revealed she was not provided annual dementia training. NA #7's date of hire was 7/1/10. Review of in-service records revealed she was not provided annual dementia training. NA #8's date of hire was 6/16/09. Review of in-service records revealed she was not provided annual dementia training. NA #9's date of hire was 6/17/13. Review of in-service records revealed she was not provided annual dementia training. On 2/16/22 at 4:00 PM, the Director of Nursing (DON) stated she reviewed the in-service records for NA's #6, #7, #8 and #9 and could not find documentation that they were provided dementia training last year. During an interview with the MDS Coordinator on 2/17/22 at 1:54 PM, she indicated that she had been the former Staff Development Coordinator for a few months prior to September 2021. She	F 947	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F947 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide nursing assistant annual dementia training. 1. Corrective action for resident(s) affected by the alleged deficient practice: Nursing Assistants #6, 7, 8 and 9 will complete Dementia Training ("Care of the Cognitively Impaired Resident") in Health Care Academy online training by 03/18/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/25/2022 the Director of Nurses began auditing all nursing assistants to identify completion of annual	

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F 947	Continued From page 148 explained annual dementia training was completed through an electronic learning system (Healthcare Academy) but she did not keep up with which staff did or did not have annual training. The DON was interviewed on 2/17/22 at 5:33 PM and indicated she started employment at the facility in January 2022. The DON stated she felt there was no oversight or accountability prior to her employment at the facility resulting in the required NA training for dementia not being completed. She added it was her expectation for all active NAs to be up to date with dementia training.	F 947	Dementia training. This audit was completed as of 02/25/2022. 1 certified staff nursing assistant had completed annual Dementia Education and no agency nursing assistants were in compliance. Any CNA identified without completed Dementia training will complete the course “Care of the Cognitively Impaired Resident” in Health Care Academy online training by 03/28/2022 and any agency nursing assistants will be provided Dementia education by 3/28/2022. The Director of Nurses will begin monitoring as of 2/25/2022 for ongoing compliance on a quarterly basis for both staff and agency certified nursing assistants. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/25/2022, the Director of Nurses fired Dementia Training (in Health Care Academy online training) via Health Care Academy on line training to all full time, part time and as needed nursing assistants that did not have the annual education documented. All identified nursing assistants will complete the Dementia training by 03/28/2022 at which time all identified nursing assistants must be in-serviced prior to working. All agency certified nursing assistants will be provided Dementia education by 3/28/2022 prior to working. This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 947	Continued From page 149	F 947	all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Support Nurse will monitor compliance utilizing the Dementia Training Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor all nursing assistants for compliance with the completion of annual Dementia training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	