STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 02/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 01/24/22 through 02/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7PVX11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/24/22 to conduct a recertification and complaint investigation survey and exited on 02/01/22. Additional information was obtained on 02/07/22 and 02/14/22. Therefore, the exit date was changed to 02/14/22. Event ID# 7PVX11 Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity J Past-noncompliance was identified at: CFR 483.25 at tag F686 at a scope and severity G CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. An extended survey was conducted. 5 of the 29 complaint allegations were substantiated but did not result in a deficiency. 5 of the 29 complaint allegations were substantiated resulting in deficiencies (F580, F624, F677, F677, F686, F689, F725 and F842).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		3/11/22

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

Electronically Signed | 03/05/2022

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F 580	Continued From page 1	F 580		

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)

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F 580	Continued From page 2 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to notify a Resident's Physician when two different blood pressure medications were not available for administration on 07/21/21 and 07/22/21; and when the blood pressure reading was out of normal range for 1 of 3 residents reviewed for medication management (Resident #328). Findings included: Resident #328 was admitted to the facility on 07/21/21. Resident #328's diagnoses included hypertension, peripheral vascular disease and aortic valve stenosis, multiple rib fractures and bilateral hand fractures from motor vehicle accident. The 5 day Minimum Data Set (MDS) assessment completed on 07/28/21 indicated Resident #328 was cognitively intact. The admission orders from 07/21/21 indicated Resident #328 was to receive the medications to reduce the blood pressure (BP) of Quinapril Hydrochloride (HCL) 40 mg twice daily and Atenolol-Chlorthalidone tablet 100-25 mg tablet	F 580	The facility failed to notify Resident's Physician when two different blood pressure medications were not available for administration on 07/21/21 and 07/22/21; and when the blood pressure reading was out of normal range for 1 of 3 residents reviewed for medication management (Resident #328). The MD was notified of missed doses of blood pressure medication and blood pressure reading being out of normal range on the morning of 7/22/2021 for resident #328 on 3/1/2022 by staff development coordinator and medication error was completed on 3/1/2022 by Regional Director of Clinical Services. This resident #328 no longer resides at facility. Newly admitted residents have the risk of being affected by this deficient practice of medical provider not being notified of missed medication doses and current admitted residents are at risk for blood pressures our of normal range not being communicated to the medical provider. An audit of newly admitted resident□s from 2/15/2022 to 3/1/3022 will be completed to address medications not given while awaiting delivery from pharmacy to be	

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F 580	Continued From page 3 once each day. Review of Resident #328's Medication Administration Record (MAR) indicated the 07/21/21 9:00 PM dose of Quinapril Hydrochloride (HCL) 40 mg was not administered by Nurse #4. This medication was to control high blood pressure. Nurse #4 noted "other/see nurse's notes" on the MAR for the 07/21/21 9:00 PM Quinapril dose. The Nurse Progress note from 07/21/21 at 9:00PM by Nurse #4 indicated the facility was waiting on delivery from pharmacy for Quinapril HCL for Resident #328. A phone interview was conducted with Nurse #4 on 02/01/22 at 10:44 AM regarding the 9:00 PM dose of Quinapril HCL for Resident #328 on 07/21/21 for Resident #328. She did not recall the missing med but stated if medications were not available, she would call the pharmacy and depending on what pharmacy told her, she would page the Doctor or Nurse Practitioner (NP), tell them the status and put the medication on hold till it was available. She said she would document in a nursing note that pharmacy was called and then page the NP and document the NP's response. She was informed there was no note about notifying the Practitioner in her notes and stated, "I don't recall." Resident #328's blood pressure on 07/22/21 at 2:59 AM was 191/88. No notification was documented that the Physician/NP was called. Record review indicated Resident #328's blood pressure (BP) medication Atenolol-Chlorthalidone tablet 100-25 mg tablet ordered daily was not	F 580	completed on 3/4/2022, audit will be completed by the staff development coordinator and the director of nursing. The medical provider will be notified of any missed medications and a medication error report will be completed by 3/11/2022. The findings of the audit were that 4 residents missed first dose of medication upon admission when awaiting pharmacy delivery. An audit of blood pressures will be completed on resident□s currently admitted to facility for the past seven days from 2/22/2022-3/1/2022 and blood pressure□s out of range will be communicated to medical provider and noted in progress notes on electronic medical record by licensed nurse. Audit completed on 3/4/2022. The findings of this audit were two blood pressures were out of range during look back period. The following measures that have been put into place to ensure the deficient practice does not recur are as follows; the staff development coordinator (SDC), director of nursing (DON), and/or licensed registered nurse educated current facility and agency licensed nurses to report to the medical provider/on call medical provider medications that are unavailable to be administered as ordered, and blood pressures that are outside of normal limits/outside of resident□s baseline; and to document notification of medical provider and any new orders received in electronic medical record. Newly hired facility and agency nurses will be educated upon hire and annually.	

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F 580	Continued From page 4	F 580		

given for the 07/22/21 9:00 AM dose. Nurse #5 noted "9" on the Medication Administration Record (MAR). Per legend on the MAR this indicated "other/see nurse's notes."
The Nurse Progress note dated 7/22/21 at 9:08 AM by Nurse #5 indicated the Atenolol-Chlorthalidone medication for Resident #328 was on backorder per slip from pharmacy.

Nurse #5 was interviewed via phone on 02/01/22 at 8:39 AM regarding the BP medication not given to Resident #328 on 07/22/22 at 9:00 AM. The nurse said with new admissions, everything was not always there, and she called and let the pharmacy know. She said she was sure she notified the doctor, and she thought she may not have documented the call. She stated she did not remember the scenario with the BP medication for Resident #328.

A phone interview with the Nurse Practitioner (NP) on 02/01/22 at 12:09 PM revealed she would have expected that the blood pressure of 191/88 would have been rechecked when it was elevated, and the NP or Physician to be notified of the elevated BP reading. The NP further stated she would have also expected to be notified if the blood pressure medications were not available. The NP stated the resident's body was trying to compensate from not having the medications. She said there was a potential for harm from missing the two doses, but she had no harm, as she had other BP medicines she was receiving, and her BP came back down.

A phone interview was conducted on 02/01/22 at 2:10 PM with the Director of Nursing (DON) regarding the Physician/NP not being notified of the elevated BP and the two BP medications that

The DON or licensed nurse will conduct a review of the blood pressure exemption report 5 times a week for 4 weeks, 3 times weekly for 4 weeks, and weekly for 4 weeks, or until substantial compliance is achieved and maintained. Resident□s who were noted to have blood pressures out of range will be reviewed at that time to ensure the medical provider was notified appropriately and notification and new orders if received were documented in resident□s electronic health record. Deviation from the appropriate process of notification will be corrected by the DON or a licensed nurse. The DON will bring data from audits to be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary.

Completion Date: 3/11/2022

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F 580	Continued From page 5 were not available. She stated if the BP medications were not available, and they were not available in the facility medication dispensing machine, the nurse was to call pharmacy. If the medication would not be available within 1 hour before or after the time the dose was due, the nurse was to call the Physician or the NP and obtain orders. The DON noted if the BP was above normal range or above the resident's baseline, the nurse should recheck with a manual BP cuff and report abnormalities to the Physician or NP. She said these actions should be documented in the resident's record.	F 580		
F 624 SS=G	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and family interviews, the facility failed to perform the dressing change the day of discharge, provide discharge instructions for the care of a newly acquired right heel pressure ulcer; in addition, the facility failed to provide the information needed for the family to set up the wound clinic appointment at discharge for 1 of 1 resident reviewed for discharge (Resident #328). Resident #328 was admitted to the hospital the day after discharge with a blood infection, severe heel pain and a wound infection.	F 624	The facility failed to perform the dressing change the day of discharge, provide discharge instructions for the care of a newly acquired right heel pressure ulcer; in addition, the facility failed to provide the information needed for the family to set up the wound clinic appointment at discharge for 1 of 1 resident reviewed for discharge (Resident #328).Resident #328 was admitted to the hospital the day after discharge with a blood infection, severe heel pain and a wound infection. Resident	3/11/22

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F 624	Continued From page 6 Findings included: Resident #328 was admitted to the facility on 07/21/21 from the hospital. Resident #328's diagnoses included high blood pressure, recent motor vehicle accident with multiple rib fractures and fractures of both hands, peripheral vascular disease and aortic valve stenosis. A nurse progress note dated 07/25/21 at 2:32 PM stated Resident #328 complained of pain in her right foot. The nurse removed her sock, and the resident was noted to have a new 2.5 centimeter(cm) x 3.0 cm open blister to her right heel. The area was cleansed, a petroleum based non-stick gauze was placed and a dressing was applied. A physician order was written by the NP on 07/26/21 for a wound consult and daily dressing for the right heel ulcer for Resident #328. Record review of the NP discharge note dated 07/27/21 noted the patient was to go home with health home. The NP indicated Resident #328 had the pressure ulcer (PU) on her right heel and the heel and foot were wrapped. The NP recommended the resident was to follow up with outpatient wound care and to follow up with her Primary Care Provider. Resident #328 was discharged on 07/28/21 before the wound consult was done. Review of the nurse progress note from 07/28/21 indicated the pressure ulcer dressing was not	F 624	is no longer admitted to the facility. Resident□s being discharged home from the facility with wounds are at risk to be affected by the deficient practice. The Staff Development Coordinator will audit resident□s that have been discharged to home from facility with wounds over the past 30 days to ensure discharge instructions including wound care and appointments for follow up were included in discharge and reviewed with resident. The audit will be completed on 3/11/2022.Any negative Findings of the audit will be corrected, and resident and resident's representative notified. The following measures that have been put into place to ensure the deficient practice does not recur are as follows; Social Services Director, Wound Care Nurse, and current facility and agency licensed nursing staff were educated on; discharge instructions, what needs to be included in discharge instructions including wound care instructions, follow up appointment and referrals (how to make the appointments), copy of medications and directions on how to take, any needed prescriptions; a signed copy of discharge instructions will be uploaded into electronic health record. The Social Services Director, licensed nurses, and medical provider will collaborate to ensure resident has all needed information for a safe discharge and to ensure resident receives scheduled wound treatments prior to discharging from the facility. Newly hired	

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F 624	Continued From page 7 done prior to discharge home. The nurse progress noted dated 07/28/21 at 4:02 PM indicated the heel PU dressing was not done by Nurse #9 due to Resident #328 being discharged home. The instructions provided to Resident #328 and a family member at discharge did not include any information for pressure ulcer care. The Home Health Certification form dated 7/27/21 completed by the NP noted recommend outpatient wound care and follow up with Primary Care Provider. No wound care physician was listed, no contact information or appointment. A phone interview was conducted with Nurse #9 on 01/31/22 at 9:02 AM who had cared for Resident #328 on 7/28/21. She had vague recollection of a resident with casts on her arms but was unable to answer other questions. Record review indicated a Social Services note from 07/28/21 at 2:10 PM that Resident #328 was discharged home with a family member. A phone interview was conducted on 02/14/22 at 12:32 PM with Resident #328's family member. She stated the nurse did not do her mother's heel dressing before her discharge on 07/28/21. She also noted the facility never instructed her on how to take care of the wound. The family member stated the resident had been vomiting for two days and was vomiting the day of discharge. She stated the physician was not notified of vomiting the day of discharge. The family member said, "if they would have just told me what to do with her foot and sent supplies," she could have done it. The family member stated she was told to follow	F 624	facility and agency licensed nurses, business office manager, Admissions Coordinator, and Social Services Director will be educated upon hire. The Director of Nursing will review discharges twice weekly times four (4) weeks, weekly for 4 weeks, and monthly times 2 months to ensure resident□s discharging home have appropriate instructions for a safe discharge. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to ensure compliance with safe discharges. Completion Date: 3/11/2022	

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F 624	Continued From page 8 up with wound care, but she "had no clue what to do to get a wound care physician's appointment." She stated she had called one place and was told they required more information. She said setting up the wound care referral was left completely up to her-no names or contact numbers were given. The family member stated she ended up taking her back to the hospital the next day with terrible pain from the pressure ulcer and she was still vomiting, as she had been for 3 days. The family member noted the wound was terribly infected and she had a blood infection from the pressure ulcer. She said the discharge nurse had not notified the physician of the vomiting that day. She said the hospital set up the wound care referral, placed a wound vacuum assisted closure device on the heel and coordinated home health when she was discharged home on 08/16/21 after her readmission. Review of hospital records following discharge from the Skilled Nursing Facility dated 07/29/21-08/16/21 indicated Resident #328 was diagnosed with a right foot infection and bacteremia (infection of the blood) related to the pressure ulcer. Her creatinine level (kidney function) was elevated at 1.20 (normal 0.51-0.95) and she was given 1 liter of intravenous fluids. The pressure ulcer on hospital admission was described as very red and inflamed with overlying black eschar (dead tissue). The heel wound measured 3.0 centimeters (cm) x 3.0 cm. The resident underwent a right heel wound debridement on 08/07/21.	F 624		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		3/11/22

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F 625	Continued From page 9 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to issue a written notice of bed hold policy upon transfer to 2 of 3 residents reviewed for discharge (Residents #70 and #27). Findings included: 1. Resident #70 was admitted to the facility on 11/24/2021 and readmitted on 12/21/2021. The admission Minimum Data Set assessment dated	F 625	The facility failed to issue a written notice of bed hold policy upon transfer to 2 of 3 residents reviewed for discharge (Residents #70 and #27). The written notice of transfer and bed hold policy was provided to resident representatives of Residents #70 on 3/4/2022. Facility unable to provide resident representative of #27 with notice due to recent death of resident.	

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F 625	Continued From page 10 12/28/2021 assessed Resident #70 to be moderately cognitively impaired. A nurse practitioner (NP) note dated 12/29/2021 documented Resident #70 had been discharged from the facility on 11/28/2021 and admitted to the hospital with pulmonary vascular congestion and to receive in-patient dialysis. Resident #70 was readmitted to the facility on 12/21/2021. A review of Resident #70's medical record revealed no documented evidence a written bed hold policy had been provided to Resident #70 upon discharge to the hospital. Nurse #2 was interviewed on 1/26/2022 at 8:33 PM. Nurse #2 reported she sent a medication administration record and resident demographics with a resident when they were sent to the hospital. Nurse #2 reported she was not certain if a bed hold policy was given to a resident when they transferred to the hospital. Nurse #3 was interviewed on 1/26/2022 at 8:48 PM. Nurse #3 reported she was the afternoon shift charge nurse. Nurse #3 reported when a resident was transferred to the hospital, a medication administration record and resident demographic sheet was sent with them. Nurse #3 reported a bed hold policy was not included. The Admission Coordinator (AC) was interviewed on 1/28/2022 at 2:07 PM. The AC reported a bed hold policy was included in an admission packet, but when a resident was transferred to hospital, they did not receive a second copy of the bed hold policy. The AC explained she called the resident or the resident representative and explained the bed hold policy and inquired if the	F 625	Residents who have a facility-initiated hospital transfer have the potential to be affected. The Social Services Director audited facility-initiated hospital transfers in the last 30 days 2/01/2022-3/01/2022 to identify other residents affected and provide written notice of transfer and bed hold. This audit and notification will be completed by 3/5/2022. Any negative findings will be corrected by sending bed hold policy and transfer discharge notice to resident and representative . The following measures that have been put into place to ensure the deficient practice does not recur are as follows; Social Services Director and Business Office Manager, Admissions Coordinator, and licensed nursing staff were educated on discharge notification being sent to resident representative by Administrator, education completed by 3/11/2022. Discharge notification and Bed Hold Notification will be completed on all facility-initiated hospital transfers and sent to resident representative; a copy of notification will be uploaded into electronic health record. The Social Services Director will review facility-initiated transfers during morning meeting to ensure transfer notice and bed hold has been sent. Newly hired facility and agency licensed nurses, business office manager, Admissions Coordinator, and Social Services Director will be educated upon hire and annually.	

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F 625	Continued From page 11 resident or representative wanted to sign the bed hold to ensure a bed was available for the resident ' s return. The AC reported the facility did not send a copy of the bed hold policy when any resident was transferred to the hospital. The Administrator was interviewed on 1/28/2022 at 2:15 PM. The Administrator reported the AC called residents or resident representatives after a resident was transferred to the hospital to explain the bed hold policy and a bed hold form was not sent with the resident. 2. Resident #27 was admitted to the facility on 10/8/2021. The most recent quarterly Minimum Data Set assessment dated 11/3/2021 assessed Resident #27 to be cognitively intact. Nurse #2 was interviewed on 1/26/2022 at 8:33 PM. Nurse #2 reported she sent a medication administration record and resident demographics with a resident when they were sent to the hospital. Nurse #2 reported she was not certain if a bed hold policy was given to a resident when they transferred to the hospital. Nurse #3 was interviewed on 1/26/2022 at 8:48 PM. Nurse #3 reported she was the afternoon shift charge nurse. Nurse #3 reported when a resident was transferred to the hospital, a medication administration record and resident demographic sheet was sent with them. Nurse #3 reported a bed hold policy was not included. A nursing note dated 1/27/2022 documented Resident #27 had weakness and a low blood oxygen saturation, and he was transferred to the hospital. As of 2/1/2022, Resident #27 remained hospitalized.	F 625	This process will be audited by Administrator weekly times 4 weeks, bi-weekly for 4 weeks, and monthly times 4 months. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with discharge and transfer notifications. Completion Date: 3/11/2022	

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F 625	Continued From page 12 A review of Resident #27's medical record revealed no documented evidence a written bed hold policy had been provided to Resident #27 upon discharge to the hospital. The Admission Coordinator (AC) was interviewed on 1/28/2022 at 2:07 PM. The AC reported a bed hold policy was included in an admission packet, but when a resident was transferred to hospital, they did not receive a second copy of the bed hold policy. The AC explained she called the resident or the resident representative and explained the bed hold policy and inquired if the resident or representative wanted to sign the bed hold to ensure a bed was available for the resident ' s return. The AC reported the facility did not send a copy of the bed hold policy when any resident was transferred to the hospital. The Administrator was interviewed on 1/28/2022 at 2:15 PM. The Administrator reported the AC called residents or resident representatives after a resident was transferred to the hospital to explain the bed hold policy and a bed hold form was not sent with the resident.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		3/11/22

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assessment of a resident's needs, strengths, goals, life 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.
(xv) 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 nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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F 636	Continued From page 14 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete admission comprehensive Minimum Data Set (MDS) assessment for 4 of 26 MDS reviewed (Resident #70, #324, #64, #374), and failed to complete Care Area Assessments (CAA) for 3 out of 26 CAAs reviewed (Resident #70, #324, #64). Findings included: 1. Resident #70 was admitted to the facility 11/24/2021 and readmitted 12/21/2021. The admission MDS with an assessment reference date (ARD) of 12/28/2021 and the CAA was not completed until 1/19/2022. The facility MDS nurse was not available for interview on 1/27/2022. The regional MDS consultant was interviewed on 1/27/2022 at 4:08 PM. The regional MDS nurse reported the facility MDS nurse was on leave from 12/9/2021 to the middle of January 2022. The regional MDS consultant explained that she and other MDS nurses from sister facilities were assisting to open MDS assessments and complete them during the time the facility MDS	F 636	The facility failed to complete admission comprehensive Minimum Data Set (MDS)assessment for 4 of 26 MDS reviewed (Resident#70, #324, #64, #374), and failed to complete Care Area Assessments (CAA) for 3 out of 26 CAAs reviewed (Resident #70, #324, #64). Admission comprehensive MDS assessments for four (4) out of twenty-six (26) residents reviewed (Residents #70, #324, #64, and #374) and found to be late were completed . #70 on 1/19/2022, #324 on 2/17/2022, #374 on 2/9/2022, and #64 on 1/19/2022 by MDS nurse . CAAs for three (3) out of twenty-six (26) CAAs reviewed (Residents #70, #324, and #64) and found to be incomplete were completed on #70 1/19/2022, #324 on 2/17/2022, and #64 on 1/19/2022 by MDS Nurse. Residents with currently in progress admission comprehensive MDS assessments are at risk to be affected by the deficient practice. The MDS Nurse will complete an audit for residents with admission comprehensive MDS	

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F 636	Continued From page 15 consultant was on leave, but the other facilities started having COVID-19 outbreaks and the priority shifted for those MDS nurses. The Administrator was interviewed on 1/28/2022 at 2:15 PM. The Administrator reported the facility MDS nurse had been on leave for most of December 2021 and half of January 2022. The Administrator reported the MDS nurses who were helping with the MDS assessments at the facility had outbreaks in their facilities and were unable to assist with the timely completion of MDS, CAA, and care plans. 2. Resident #324 was admitted to the facility 1/5/2022. The admission MDS ARD was 1/12/2022. The MDS was not completed and marked "in progress" with sections incomplete. The facility MDS nurse was not available for interview on 1/27/2022. The regional MDS consultant was interviewed on 1/27/2022 at 4:08 PM. The regional MDS nurse reported the facility MDS nurse was on leave from 12/9/2021 to the middle of January 2022. The regional MDS consultant explained that she and other MDS nurses from sister facilities were assisting to open MDS assessments and complete them during the time the facility MDS consultant was on leave, but the other facilities started having COVID-19 outbreaks and the priority shifted for those MDS nurses. The Administrator was interviewed on 1/28/2022 at 2:15 PM. The Administrator reported the facility MDS nurse had been on leave for most of December 2021 and half of January 2022. The Administrator reported the MDS nurses who were	F 636	assessments currently in Progress to identify any late assessments and/or incomplete CAAs. The audit was completed on3/2/2022 by MDS nurse.The findings of the audit were as follow: 18 admission comprehensive assessment were in progress and will be completed by 3/11/2022 . The following measures that have been put into place to ensure the deficient practice does not recur are as follows Facility MDS nurse(s) will be re-educated by the Regional MDS nurse and/or Regional Director of Clinical Services (RDCS) on timely completion of Comprehensive Assessments and timely completion of CAAs on/before 3/11/2022. The Director of Nursing, Regional MDS Nurse, Regional Director of Clinical Services, and/or Staff Development Coordinator will complete an audit of MDS Admission Comprehensive Assessments in Progress to identify late assessments three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, then weekly for four (4) weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to	

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F 636	Continued From page 16 helping with the MDS assessments at the facility had outbreaks in their facilities and were unable to assist with the timely completion of MDS, CAA, and care plans. 3. Resident #64 was admitted to the facility 12/15/2021. The admission MDS with an ARD of 12/22/2021 was completed on 1/9/2022. The CAA and care plan decisions were also completed on 1/9/2022. The facility MDS nurse was not available for interview on 1/27/2022. The regional MDS consultant was interviewed on 1/27/2022 at 4:08 PM. The regional MDS nurse reported the facility MDS nurse was on leave from 12/9/2021 to the middle of January 2022. The regional MDS consultant explained that she and other MDS nurses from sister facilities were assisting to open MDS assessments and complete them during the time the facility MDS consultant was on leave, but the other facilities started having COVID-19 outbreaks and the priority shifted for those MDS nurses. The Administrator was interviewed on 1/28/2022 at 2:15 PM. The Administrator reported the facility MDS nurse had been on leave for most of December 2021 and half of January 2022. The Administrator reported the MDS nurses who were helping with the MDS assessments at the facility had outbreaks in their facilities and were unable to assist with the timely completion of MDS, CAA, and care plans. 4. Resident #374 was admitted to the facility on 12/16/21 with the diagnoses of altered mental status and kidney failure.	F 636	maintain compliance with comprehensive assessments and timing. Completion Date: 3/11/2022	

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F 636	Continued From page 17 Resident #374's admission Minimum Data Set (MDS) dated 1/6/22 was observed as not completed. The Regional MDS Coordinator was interviewed on 1/26/22 at 2:45 pm. She stated that there was no facility MDS Coordinator during most of December 2021 into January 2022. She stated the MDS would have to be completed and submitted. On 1/27/22 at 5:00 pm an interview was conducted with the Administrator. She stated that she was aware that some of the MDS were not completed due to the facility MDS coordinator not being available. The Regional MDS Coordinator was going to complete and submit the required MDS.	F 636		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, and observations the facility failed to correctly code Minimum Data Set (MDS) assessments in the areas of infection, and brief interview for mental status (BIMS) (Resident # 20), dental (Resident #59) and smoking (Resident #27) for 3 of 26 residents reviewed for MDS accuracy. The Findings included: 1. Resident #20 was admitted to the facility on	F 641	The facility failed to correctly code Minimum Data Set (MDS) assessments in the areas of infection, and brief interview for mental status (BIMS) for Resident # 20, dental for Resident #59, and smoking for Resident #27 for 3 of 26 residents reviewed for MDS accuracy. MDS corrections were initiated for residents #20, 59, and 27 and completed by MDS Nurse on 1/27/2022, #59 on 1/27/2022, and #27 on 1/28/2022 and completed by MDS Nurse.	3/11/22

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F 641	Continued From page 18 10/8/16 with a diagnosis of chronic obstructive pulmonary disease. a. A review of the previous MDS quarterly assessment dated 10/22/21 coded Resident #20 as being severely cognitively impaired. The annual assessment dated 10/1/21 coded the resident as being cognitively intact. b. Resident #20 quarterly MDS assessment dated 12/29/21 indicated Resident #20 was coded as being cognitively intact and had been assessed as having pneumonia. A record review revealed Resident #20 had a urinary tract infection as of 12/21/21 and was started on antibiotic therapy on 12/21/21. There was no documentation in the record review that Resident #20 had pneumonia during the lookback period. A phone interview was completed with the MDS nurse on 1/27/22 at 4:59 PM who stated that she meant to code UTI and coded pneumonia instead. The MDS nurse stated she knew Resident #20 had an infection and clicked the wrong buttons and it was an oversite. The MDS nurse was asked about Resident #20's cognition score on the quarterly 10/22/21 assessment and she stated the former Social Worker filled out section C. The MDS nurse stated that Resident #20 was cognitively intact and to code Resident #20 as severely cognitively impaired was not accurate. A phone interview was completed with the former Social Worker (SW) on 1/31/22 at 4:27 PM regarding Resident #20's cognition score on the quarterly assessment on 10/22/21. The former	F 641	Residents currently admitted to the facility are at risk to be affected by the deficient practice. The MDS Nurse and Regional MDS Nurse and Regional Director of Clinical Services will complete an audit of MDS assessments, reviewing the care areas of infection, cognitive, dental, and smoking that were completed and submitted within the last thirty (30) days. Audit will be completed to identify inaccurately coded assessments and issues identified will be corrected and MDS assessments will be resubmitted by 3/11/2022. The following measures that have been put into place to ensure the deficient practice does not recur are as follows Facility MDS nurse(s)and Social Services Director will be re-educated by the Regional MDS nurse on MDS assessment care areas pertaining to Cognitive, dental, infection, and smoking. Education completed on 3/11/2022. Newly hired MDS nurses and Social Services Director will be educated upon hire. The Director of Nursing, Regional MDS Nurse, Regional Director of Clinical Services, and/or Staff Development Coordinator will complete an audit of MDS Assessment care areas of Cognitive, dental, infection, and smoking three (3) times weekly for four (4) weeks, then two (2) times weekly for four (4) weeks, then weekly for four (4) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the	

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F 641	Continued From page 19 SW stated that it was a mistake and inputted the data wrong. She stated that she knew the resident well and her memory was intact. The former SW stated that she was probably rushing and had just learned the software. 2. Resident #59 was admitted to the facility on 8/7/20 with a diagnosis of ulcerated colitis and delirium. The annual MDS assessment dated 6/3/21 section L oral dental status coded Resident #59 as having no natural teeth or teeth fragments. An observation and interview of Resident #59 on 1/24/22 at 10:52 AM revealed she had teeth. Resident stated that she had saw a dentist to clean her teeth a couple of months ago. A record review showed Resident #59 had her teeth cleaned by a hygienist on 12/15/21. A phone interview was completed with the MDS nurse on 1/27/22 at 4:51 PM who stated she had made a mistake by coding Resident #59 as having no teeth, and she did Resident #59's admission assessment and knew Resident #59 well and this was an oversite. An interview was completed with the Administrator on 1/28/22 at 4:49 PM who stated that it would be her expectation the MDS matches the resident accurately. 3. Resident #27 was admitted to the facility on 8/29//21. A smoking assessment was completed on 10/08/21 for Resident #27. The resident was assessed as being a safe smoker, not requiring	F 641	deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with comprehensive assessments and timing. Completion date: 3/11/22	

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F 641	Continued From page 20	F 641		

supervision.

The Admission Minimum Data Set (MDS) assessment completed on 10/15/21 indicated Resident #27 was cognitively intact. The assessment was coded as "No" that the resident did not have "Current Tobacco Use."

During the survey, the facility provided a list of current residents that smoked, and Resident #27 was included on the list.

Observations were conducted of Resident #27 on 01/26/22 in the smoking area smoking a cigarette.

An interview was done on 01/28/22 at 12:26 PM with MDS nurse #1 regarding Resident #27's Admission assessment. She stated the 09/04/21 Admission MDS was coded incorrectly for "Current Tobacco User" and should have been a "Yes."

An interview was conducted with the Administrator on 01/28/22 at 4:49 PM regarding MDS assessments. She stated she expected the MDS assessments to be coded accurately.

4. Resident #328 was admitted to the facility on 07/21/21.

Admission skin assessment for Resident #328 completed on 07/21/21 revealed no skin breakdown on heels.

The Nurse Progress Note dated 07/25/21 revealed Resident #328 was complaining of right foot pain, the sock was removed and noted a 2.5 centimeter (cm) x 3.0 cm open blister to her right

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F 641	Continued From page 21	F 641		

heel.

The Discharge MDS assessment dated 07/28/21 did not code a pressure ulcer.

MDS Nurse #1 was interviewed on 01/28/22 at 11:57 AM regarding Resident #328's MDS discharge assessment. She was asked about the pressure ulcer not being coded and stated she had reviewed the nurse's notes and only saw an open blister on the nurse's notes and not anything additional when she did the discharge MDS. She was asked about the Nurse Practitioner's note from 07/26/21 that indicated a pressure ulcer had developed and the MDS nurse stated the note was not uploaded when she completed the assessment on 08/03/21. The care plan was reviewed with the MDS nurse and reviewed the revision date of 07/26/21 for the entry that indicated a pressure ulcer area to right heel and to continue treatment until healed. She stated these were entered by MDS Nurse #2. MDS Nurse #1 stated she was unable to accurately code the discharge MDS assessment when information from 07/26/21 was not uploaded until 08/07/21 after the discharge assessment was completed. She stated they talked about pressure ulcers in the morning meetings but without information in the medical record she cannot code it.

An interview was completed with the Administrator on 01/28/22 at 4:49 PM regarding the Discharge MDS assessment for Resident #328. She stated she would want the MDS assessment to match the resident accurately and the pressure ulcer should have been included. She noted she would have expected the MDS nurses to hear the report in the morning meetings

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	345130	A. BUILDING _____ B. WING _____	C 02/14/2022

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ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22 and enter it in the MDS. The Administrator also noted there was a file for residents in Medical Records with information to be uploaded that was available to the MDS staff.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		3/11/22

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F 655	Continued From page 23 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission to address the immediate needs of a resident for enteral feedings or identify the correct smoking status for 1 of 2 residents reviewed for baseline care plans (Resident #27). The findings included: Resident #27 was readmitted to the facility on 10/08/21. Resident #27's diagnoses included dysphagia and history of laryngeal cancer. The Admission Minimum Data Set (MDS) assessment completed on 10/15/21 indicated Resident #27 was cognitively intact. A review of the physician orders indicated Resident #27 was ordered enteral feeding every 4 hours, 240 cubic centimeters (cc) with a start date of 10/08/21. Review of the Medication Administration Record	F 655	The facility failed to develop a baseline care plan within 48 hours of admission to address the immediate needs of a resident for enteral feedings or identify the correct smoking status for 1 of 2 residents reviewed for baseline care plans (Resident #27). The resident□s care plan was updated to show correct data on comprehensive care plan that was now active. Correction was made on 3/4/2022. Newly admitted residents are at risk of being affected by the deficient practice. The Minimum Data Set (MDS) nurse will complete an audit of resident□s admitted within the past 21 days, baseline care plans will be reviewed to ensure enteral feeding and smoking status are correctly identified on their baseline care plans. Audit and Issues identified will be completed by 3/11/2022 Any corrections made will be reviewed with the resident and/or their responsible party by the MDS nurse or Director of Nursing. Negative findings of the audit will be corrected by 3/11/2022.	

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F 655	Continued From page 24 indicated Resident #27 received the tube feeding as ordered on 10/08/21 from 10/08/21 until 12/07/21. A smoking assessment was completed on 10/08/21 for Resident #27. The resident was assessed as being a safe smoker, not requiring supervision. The Baseline care plan completed on 10/11/21 indicated Resident #27 was NPO (Nothing by Mouth). The box for tube feeding was not checked. The question "Is this resident a smoker?" was checked "no" on Resident #27's baseline care plan. It was signed with a date of 10/11/21. An observation was conducted of Resident #27 on 01/26/22 in the smoking area and he was smoking a cigarette. An interview completed with Resident #27 was done on 01/25/22 at 10:10 AM. He stated he had a feeding tube in place, was gaining weight and was hoping to be able to eat enough to not require the enteral feeding. Resident stated he was a smoker. An interview was done on 01/27/22 at 04:03 PM with the Unit Manager (UM)/Former Interim Director of Nursing. She stated the baseline care plan (BCP) pulled information from the initial admission assessment and should have included smoking, enteral tubes and tube feedings. She noted the BCP should be done within 48 hours including weekends and be accurate. She noted it should be reviewed with the Resident/Responsible Party (RP) and if the RP was not available the evening supervisor would	F 655	The regional MDS nurse will educate the MDS nurse, Social Services Director, Activities Director, Director of Nursing, Certified Dietary Manager, and Therapy Director, and facility and agency licensed nurses regarding smoking and feeding status on base line care plans. Education will be completed by 3/11/2022. Newly hired MDS nurse, Social Services Director, Activities Director, Director of Nursing, Certified Dietary Manager, and Therapy Director, and facility and agency licensed nurses will be educated upon hire. The Director of Nursing, MDS Nurse, and Staff Development Coordinator will complete an audit of baseline care plans to identify inaccuracies in the identified areas of concern □ enteral feeding and smoking - three (3) times weekly for 4 weeks, then two (2) times weekly for four (4) weeks, then weekly for four (4) weeks to ensure accuracy. The Director of Nursing will review audits completed by MDS nurse for to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with baseline care	

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F 655	Continued From page 25 call and review it with them.	F 655	plans. Completion Date: 3/11/2022	
F 657 SS=D	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 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 observations, record review and staff interviews, the facility failed to revise a nutrition care plan for 1 of 1 resident reviewed for nutrition	F 657	The facility failed to revise a nutrition care plan for 1 of 1 resident reviewed for nutrition (Resident #27). The resident□s	3/11/22

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F 657	Continued From page 26	F 657		

(Resident #27).

Findings include:

Resident #27 was readmitted to the facility on 10/08/21.

Resident #27's diagnoses included Chronic Obstructive Lung Disease (COPD), diabetes, heart failure, atrial fibrillation, dysphagia and history of laryngeal cancer.

The Admission Minimum Data Set (MDS) assessment completed on 10/15/21 indicated Resident #27 was cognitively intact. It was noted he had no swallowing disorder.

Record review of a swallowing study completed on 10/27/21 indicated Resident #27 was recommended minced and moist solid food, mildly thickened liquids and medication to be whole in puree or applesauce.

A physician order for Resident #27 for a regular diet, mechanical soft texture and nectar thickened fluids was ordered on 10/29/21.

Record Review of Resident #27's care plan indicated the resident was NPO. This intervention was initiated on 08/30/21 and revised on 10/28/21.

The Dietitian Progress note dated 1/10/22 revealed Resident #27 was receiving enteral feedings and was continued on a mechanical soft diet with thickened liquids.

The care plan for Resident #27 was reviewed on 1/26/22 the NPO status was on the care plan and

care plan was updated to reflect accurate information on 2/17/2022.

Resident□s that are currently admitted are at risk to be affected by the deficient practice. The Minimum Data Set (MDS) nurse and Regional MDS Nurse will complete an audit of nutrition care plans and current diet orders to be completed by 3/5/2022. Correction will be made for inaccuracies and completed by 3/11/2022.

The Regional MDS nurse will educate the MDS nurse, registered dietician, and certified dietary manager on nutrition care plans and updating when new orders are received. The education to be completed on3/11/2022 .

The Director of Nursing, MDS Nurse, and Staff Development Coordinator will complete an audit of nutrition care plans to ensure care plan is current with current diet order; audits to be completed three (3) times weekly for 4 weeks, then two (2) times weekly for four (4) weeks, then weekly for four (4) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance

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F 657	Continued From page 27 no information regarding thickened liquids was listed. An interview was done on 01/28/22 at 12:26 PM with MDS Nurse #1 regarding Resident #27's Admission assessment. She stated MDS staff were responsible to update the care plans. MDS nurse #1 was asked about the NPO (Nothing by Mouth) status on the care plan and stated she thought she had removed it. She noted he was NPO on admission, the meals had been added a while ago, and he was no longer NPO. She noted the care plan should have been updated with his new diet information. A follow up interview with MDS Nurse #1 completed on 01/28/22 was done and she provided a copy of an "Order Audit Report" which indicated the NPO order had been discontinued on 10/29/21 when the resident was upgraded to a mechanical soft diet. She noted the care plan should have revised. An interview was done on 01/27/22 at 04:03 PM with the Unit Manager (UM)/Former Interim Director of Nursing. She stated the MDS nurse was responsible to update the care plans. The UM noted the MDS nurse reviewed the orders and received information in the morning meetings to revise/update the care plan as needed. She noted nursing did not update the care plan The UM added Speech Therapy usually completed the written order for diet change modifications and the MDS nurse should have updated the care plan with the order change. A phone interview was conducted with the Director of Nursing (DON) on 02/01/22 at 2:10 PM regarding care plans. She stated new orders	F 657	with baseline care plans. Completion Date: 3/11/2022	

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F 657	Continued From page 28 and resident updates were done in the Interdisciplinary Team (IDT) meetings. She noted normally the MDS nurse did the care plan updates but she had updated care plans and usually care plans were updated during the IDT meetings Monday-Friday.	F 657		
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 observation, record review and interview of the staff, residents, and family member, the facility failed to provide incontinence care to residents who were dependent for activities of daily living for 3 of 8 residents (Resident #4, 5, and 374). Findings included: 1. Resident #4 was admitted to the facility on 2/3/11 with the diagnoses of other neurological condition. Resident #4's quarterly Minimum Data Set dated 1/3/22 documented an intact cognition. The resident required extensive assistance for transfer, bathing, and dressing. The resident was incontinent of bowel and bladder. Resident #4's care plan dated 1/23/22 documented the resident was non-ambulatory and leans to the side frequently. The resident required assistance with her activities of daily	F 677	The facility failed to provide incontinence care to residents who were dependent for activities of daily living for 3 of 8 residents (Resident #4, 5, and 374). Incontinence was provided at the time it was brought to the staff□s attention on for resident # 374, #4, and #5 on 1/26/2022 when facility was made aware of delay. Residents□ who are dependent for Activities for Daily Living (ADL) care are at risk for the deficient practice. An audit of residents□ that are listed as dependent for incontinence care on Minimum Data Set Assessment Section H and have a Brief Interview for Mental Status (BIMS) of 11 or higher will be interviewed by the Director of Social Services regarding the timeliness of their incontinence care. Resident□s who have a BIMS 10 and below; rounding will be completed by the staff development coordinator and Unit Manager on these residents to review for	3/11/22

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F 677	Continued From page 29	F 677		

living. The resident was incontinent of bowel and bladder with an overactive bladder and was dependent on staff for incontinence care. The resident was at risk for urinary tract infection. Interventions included: Check for incontinent episodes during care rounds and as required for incontinence and change clothing as needed after incontinence episodes.

On 1/24/22 at 5:15 pm an interview was conducted with Resident #4's family member. The family member stated that she had visited on several occasions and found the resident wet with urine and urine odor. When the family member placed the call light on or asked staff, they would not respond for a long time (over an hour).

A review of the documented nurse staffing for 1/26/22 revealed there were three nursing assistants assigned for day shift.

On 01/26/22 at 11:00 am incontinence care was observed for Resident #4. The resident was urine soaked through her undergarment, incontinence pad, and sheet to the mattress. The bed was observed to be wet from side to side and up the resident's back. Nursing Assistant (NA) #1 turned the resident and bowel movement was found. The NA washed the resident's back as well as incontinence care. Urine odor was very strong.

On 1/26/22 at 11:20 am an interview was conducted with NA #1. She stated Resident #4 had not received incontinence or morning care this day shift (7 am to 3 pm) 1/26/22 until 11:00 am. She stated that there was not enough staff. She had 16 residents for her day shift assignment today and there were only 3 NAs on this shift. NA stated 11:00 am was the first time she was able

signs of urine/feces odors, excessively soiled, or skin breakdown. This audit will be completed by 3/11/2022. Findings will be documented and reviewed by the Director of Nursing and Administrator. No additional concerns identified during observation.

The Staff Development Coordinator (SDC), Director of Nursing (DON), and/or Licensed Registered Nurse will educate current facility and agency licensed nurses and current facility and agency certified nursing assistants on the timeliness of bowel, bladder incontinence care and incontinence care policy. Education to be completed by 3/11/2022. Newly hired facility and agency licensed nurses and facility and agency certified nursing assistants will be educated upon hire.

The Director of Nursing (DON) and Staff Development Coordinator will conduct an audit of incontinence care to dependent residents, five (5) times weekly for four (4) weeks, then three (3) times weekly for four (4) weeks, then weekly for four (4) weeks or substantial compliance is achieved and maintained. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will

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F 677	Continued From page 30 to provide incontinence care for Resident #4 due to staffing and her assignment. NA #1 stated she usually provided care every 2 hours but had too many residents to care for. NA #1 stated that management were aware of the assignment, inability to complete assignment was not reported. An interview was conducted with the Director of Nursing (DON) on 1/27/22 at 9:30 am. The DON stated she was not aware of NA #1's inability to provide incontinence care every 2 hours. The DON stated that staff were pulled to move 5 COVID positive residents into a COVID unit that was being put together at the same time. The DON stated she was aware of the staffing assignment and that there were less nursing available for resident care during this time. 2. Resident #5 was admitted to the facility on 1/7/20 with the diagnosis of dementia. Resident #5's quarterly Minimum Data Set dated 10/4/21 documented she was severely cognitively impaired. She was activity of daily living (ADL) dependent. The resident was incontinent of bowel and bladder. Resident #5's care plan dated 10/18/21 documented she had an ADL self-care performance deficit from right-sided hemiplegia and generalized weakness. She was dependent on staff for all her self-care needs. The goal was the resident's self-care needs will be anticipated and met by staff daily. Interventions included: one staff to bath, dress, and groom resident daily and as needed. On 1/25/22 at 10:10 am an observation was done	F 677	be made to the plan as necessary to maintain compliance with incontinence care for residents who are dependent for Activities of Daily Living. Completion date: 3/11/22	

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F 677	Continued From page 31	F 677		

of Resident #5. She was lying in her bed. There was urine odor and a small to moderate amount of yellow colored liquid on the incontinence pad and resident's clothing.

On 1/26/22 at 11:45 am Resident #5 was observed in her bed. She had a noticeable wet yellow ring around the torso and buttocks of her body on the incontinence pad and sheet with urine odor. Nursing Assistant (NA) #2 was assisting the roommate (Resident #374) with incontinence care.

On 1/26/22 at 11:50 am an interview was conducted with NA #2. She stated that she was not sure the last time Resident #5 had received incontinence care. She was assigned to this resident room for day shift (7 am to 3 pm). She had no comment regarding the NA assignment for day shift.

An interview was conducted with the Director of Nursing (DON) on 1/27/22 at 9:30 am. The DON stated she was not aware of NA #2's inability to provide incontinence care every 2 hours. The DON stated that staff were pulled to move 5 COVID positive residents into a COVID unit that was being put together at the same time. The DON stated she was aware of the staffing assignment and that there were less nursing available for resident care during this time.

3. Resident #374 was admitted to the facility on 12/16/21 with the diagnoses of altered mental status and kidney failure.

Resident #374's care plan dated 12/16/21 documented the resident required assistance with

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F 677	Continued From page 32 her activities of daily living. On 1/26/22 at 11:00 am an observation and interview were done of Resident #374. NA #2 changed the resident for incontinence of urine and stool. The bed, pad, and sheet were noted to be very wet with yellow liquid and urine odor was noted. The NA reported she did not know when the last incontinence change had taken place. "I was asked to provide care by the nurse because the tube feed had leaked in the bed." Stool was large and the linen was wet. Urine odor was noted. The NA used four changes of gloves to complete incontinence care and changed all linens due to the level of soiling. An interview was conducted with the Director of Nursing (DON) on 1/27/22 at 9:30 am. The DON stated she was not aware of NA #2's inability to provide incontinence care every 2 hours. The DON stated that nursing staff were pulled to move 5 COVID positive residents into a COVID unit that was being put together at the same time. The DON stated that she was informed by NA #2 tube feeding had leaked into Resident #374's bed on 1/26/22 when incontinence care was observed. NA #2 was assigned to the resident's room.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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	F 686		3/4/22

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F 686	Continued From page 33 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 and staff and nurse practitioner interviews, the facility failed to assess and implement interventions for pressure ulcer prevention and notify the provider of heel redness which resulted in a newly identified pressure ulcer to the right heel for 1 of 2 residents reviewed for pressure ulcers. In addition, the facility failed to assess the wound and complete daily pressure ulcer dressing changes for 2 of 4 consecutive dates (Resident #328). Subsequently, the resident was readmitted to the hospital the day after discharge with a wound infection. Findings included: Resident #328 was admitted to the facility on 07/21/21 from the hospital. Resident #328's diagnoses included high blood pressure (HBP), recent motor vehicle accident with multiple rib fractures and fractures of both hands, peripheral vascular disease and aortic valve stenosis. Record review of the hospital Physician progress note dated 07/19/21 indicated Resident #328's peripheral pulses were 2+(normal), skin was warm with 1+(slight) edema in her lower extremities. She had a normal ejection fraction (heart pumping ability) of 60-65%. Her total	F 686	Past noncompliance: no plan of correction required.	

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protein level was 6.8 on 07/09/21 with a normal range of 6.3-8.3 grams/deciliter.

The admission assessment completed on 07/21/21 at 14:27 PM noted Resident #328 was total dependence for bed mobility, transfer, dressing and personal hygiene. The skin assessment revealed she had bruising to knees, shins and mild swelling of her right ankles and casts on both forearms. Her pain was listed as mild with a rating of 4 on a 0-10 scale. The resident's pain was in her hands, left ankle, left leg and left rib cage area. The skin was normal color and turgor, and the temperature was warm. The admission assessment indicated Resident #328's skin was intact without redness on both heels.

A phone interview was done on 01/31/22 at 04:10 PM with Nurse #7 that completed the skin assessment on 07/21/21 on Resident #328. She recalled the resident and stated she could not turn well due to discomfort. She said skin assessments were done on admission and on shower days. She noted on shower days, the Nurse Assistant (NA) signed the skin assessment and then the nurse reviewed it and signed it. She noted the mattress on the bed was supposed to prevent skin breakdown. She was asked if preventive measures should have been used to prevent skin breakdown and placed on the care plan. Nurse #7 stated that was a nursing and therapy judgement and could also be communicated nurse to nurse in report. She added that using a pillow and floating heels off the bed could be checked off in the medical record as an intervention, and then it would display on the Treatment Administration Record (TAR), and the nurse would have to check it off

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on the TAR.

The Baseline Care plan completed on 07/21/21 indicated Resident #328 required the physical assistance of 1 person with toileting and bed mobility, and that transfers and walking did not occur.

The care plan for Resident #328 initiated on 07/22/21 listed the care areas as:
1) Activities of Daily Living (ADL) self-care decline with the interventions of bed mobility-the resident is able to (SPECIFY- area not specified) and skin inspection-the resident requires skin inspection (SPECIFY frequency- area not specified) and to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.
2) An additional care area noted the resident had (SPECIFY-area not specified) pressure ulcer (SPECIFY LOCATION- area not specified) or potential for pressure ulcer (PU) development r/t immobility which was initiated on 07/22/21. Interventions were to follow facilities policies/protocol for the prevention and treatment of skin breakdown.

A nurse progress note dated 07/22/21 indicated Resident #328 was non-weight bearing for upper extremities bilaterally.

Review of the Facility Skin Assessment policy revised 10/28/20 revealed a full body skin assessment was to be completed on admission, daily for three days, then weekly thereafter.

The facility policy revised 10/28/20 for Pressure Injury Prevention and Management indicated repositioning would be done of all residents at risk every 2 hours and staff were to ensure heels

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were floated off the bed.

The Nurse Practitioner (NP) Day 1 progress note dated 7/22/21 revealed Resident #328 was dependent on a wheelchair for mobility. The resident also had some bruising on her right leg, pedal pulses were present on both feet, and she had no peripheral edema.

The July TAR were reviewed for Resident #328. It indicated a skin assessment should be done weekly on Thursday and was signed on 7/22/22 by Nurse #5.

A phone interview was done on 01/31/22 at 10:41 AM with Nurse #10 who cared for Resident #328 on 07/23/21. She noted the resident was up in the chair and did not recall any heel pain. She stated she assisted her with toileting, and she did not recall elevating her heels or doing anything special for the heels. She noted the resident was unable to pivot her lower extremities or bear much weight. She stated skin assessments were done on admission and she was not aware of the ongoing skin assessments requirements.

A phone interview was done with Nurse #11 who cared for Resident #328 on 7/21/21, 7/23/21 and 7/24/21. She stated skin assessments were done on admission and weekly. She was asked about pressure ulcer prevention and said it depended on the resident's needs, their mobility and any areas of concerns. She noted the nurse puts the treatments in place and then the treatment nurse did the weekly assessment.

A nurse progress note dated 07/25/21 at 2:32 PM stated Resident #328 complained of pain in her right foot. The nurse removed her sock, and the

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resident was noted to have a 2.5 centimeter(cm) x 3.0 cm open blister to her right heel. The area was cleansed, a petroleum based non-stick gauze was placed and a dressing was applied.

A skin issue report was reviewed from 07/25/21 at 11:35 AM for Resident #328 that was completed by the Unit Manager/Interim DON at the time. It indicated the resident complained of pain in her right foot, the gripper sock was removed and revealed a 5 cm x 3.0 cm open blister to the right heel. The resident stated she had sharp pain that started at her heel and went up the sole of the foot. It stated the medical director was notified on 07/25/21 at 1:45 PM.

An interview was conducted on 01/27/22 at 4:03 PM with the Unit Manager/Interim Director of Nursing (DON) in the role in July 2021. She had discovered the pressure ulcer on 07/25/21 and stated she did not recall the resident. She reviewed Resident #328's information and said she recalled the family taking her home earlier than anticipated but nothing else. The unit manager stated with a new pressure ulcer they completed a wound pressure ulcer assessment in the electronic medical record (EMR), but she was unable to locate one. She had no recall of the PU when she reviewed the EMR during the interview.

NA #6 that cared for Resident #328 on 07/22/21-7/25/21 and 07/27/21was interviewed via phone on 01/28/22 at 1:04 PM. She recalled the resident well and stated, she was totally dependent, and the NA would do most of her bath. She said she would get a second person to transfer her, and the resident would stand up and pivot with 2 people assisting her. She noted the resident would sit up a lot for comfort and not stay

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in the bed much during the day. She recalled the resident complaining of her right heel hurting and a blister. She could not recall if it was an open blister or not. She said the resident did not complain initially but after a few days there, she complained of her heel. The NA stated she complained about her heel when it was only a little red spot and not open. The NA recalled one time when she complained of her heel, and said the resident was bawling and the NA took her sock off and rubbed cream on it. The NA said she would elevate her heel when she was in her wheelchair by placing it up on a pillow and pulling the foot pedal up to elevate it. She recalled the resident having her own different colored gripper socks and thought her socks were usually changed daily.

A revision to Resident #328's care plan was done on 07/26/21 noted "area to right heel, continue treatment until healed."

A physician order was written by the NP on 07/26/21 for a wound consult and treat for right heel ulcer for Resident #328.

Record review of Resident #328's July 2021 TAR noted a treatment with the start date of 07/26/21 to cleanse right heel with wound cleanser, pat dry, apply xeroform gauze and cover with a protective dressing daily every day shift. It was documented as "9" on 07/26/21(MAS), completed on 07/27/21 and "9" on 07/28/21 by Nurse #9. Per the TAR legend "9" indicated Other/See Nurse Notes.

The nurse progress noted dated 07/26/21 at 2:58 PM revealed the heel pressure ulcer (PU) dressing was not done by Nurse #8 due to family

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request as Resident #328 was "resting following pain medication and her lack of sleeping." Nurse #8 had medicated the resident with a pain pill at 1:47 PM.

The 5 day Minimum Data Set (MDS) assessment completed on 07/28/21 indicated Resident #328 was cognitively intact. The MDS indicated the resident was at risk for pressure ulcer/injury. No pressure ulcers, wounds or skin problems were identified. Per the MDS Skin and Ulcer/Injury Treatment section there was no treatments applied for pressure reducing device for bed, turning/repositioning program or nutrition.

A follow up phone interview was done on 01/31/22 at 2:55 PM with the Unit Manager/Interim DON in the role in July 2021. She was asked about skin assessments and stated they were done on admission, the first 3 days and then weekly. She was asked if this was on the MAR/TAR as a task and stated the facility staff nurses knew to do it by routine. When asked how this was communicated to the agency nurses, she stated she did not know that it was, and it was not on the MAR/TAR. The Manager/Interim DON said nothing was set in place for prevention automatically with residents that don't have a concern on admission. She said the resident was able to use her feet, so nothing was put in place for prevention.

MDS Nurse #1 was interviewed on 01/28/22 at 11:57 AM about Resident #328's care plan. She reviewed the medical record for the 7/21/21 admission assessment and saw bruising was noted and she had no pressure ulcer. She was asked about the care plan initiated on 7/22/21, with a care area for pressure ulcer and potential

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for pressure ulcer and stated when everyone was admitted, they initiated a potential risk for pressure ulcer. MDS nurse #1 noted on 7/26 that MDS Nurse #2 had added to "continue dressings until healed and put interventions for the pressure ulcer in."

An interview was done via phone with Nurse #4 that cared for Resident #328 on 07/21/21, 07/24/21 and 07/25/21. She was asked about skin assessments and pressure ulcer prevention. She stated head to toe skin assessments were done on admission and then weekly. She said a resident's heels should be propped up no matter what, and interventions should be placed in the treatment orders to float the heels, skin prep to heels if they were red or boggy and both displayed on the TAR. She was informed these were not on the TAR and she said she did not recall the resident.

An interview was done with Nurse #12 via phone on 01/31/22 at 11:22 AM. She stated skin assessments were done on new admissions and then she believed the treatment nurse followed up the next day and she was not sure after that. Nurse #12 noted pressure ulcer prevention depended on the resident regarding they needed a special mattress or heels floated but it was not a routine.

Record Review indicated a NP note from 07/26/21 for the 3 day post admission follow up. It noted her history of fracture of multiple ribs (left side 2-10), MVA, ankle joint pain and bilateral hand fractures. The NP documented Resident #328 had normal skin temperature, no peripheral edema, had decreased mobility and her functional status was listed as confined to bed. It

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was noted the resident had a pressure ulcer on her right heel, the right heel and foot were wrapped and an order was place for the wound physician. The NP noted the resident stated the pressure ulcer was very painful.

Record review of a Dietician's note from 07/27/21 at 12:29 PM indicated Resident #328 was recommended to add fortified foods and stated there was no current lab work on file.

A phone interview was done on 01/31/22 at 3:26 PM with the wound nurse that was in the role since December 2021. She stated the admission nurse completed the initial skin assessment and then it was done weekly. She was not aware about the daily for 3 days skin assessment after admission or if there should be implementation of interventions for pressure ulcer prevention on admission. She stated she had not been trained as a wound nurse. She said if there were deep tissue injuries on the heels, they should put interventions in place. However, if there were no issues on the admission assessment then no interventions would be done unless the resident had a problem. She said if the resident was able to push themselves up in the bed, they were usually able to get out of bed also and no prevention was done.

Record review of the NP discharge note dated 07/27/21 noted the patient was to go home with health home. The NP indicated Resident #328 had the pressure ulcer on her right heel and the heel and foot were wrapped. It was documented the patient stated it was very painful. The discharge summary indicated she was confined to bed, had decreased mobility, no peripheral edema and the NP recommended the resident

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was to follow up with outpatient wound care and to follow up with her Primary Care Provider. Review of the nurse progress note from 07/28/21 at 4:02 PM indicated the heel PU dressing was not done by Nurse #9 due to Resident #328 being discharged home.

A phone interview was conducted with Nurse #9 on 01/31/22 at 9:02 AM. She cared for Resident #328 on 7/24/21, 7/25/21, 7/27/21 and 7/28/21. She stated skin assessments were done on admission, the first 3 days and then weekly. She said she did not know who was documenting the first three days after admission, but it was not on the TAR. She had vague recollection of a resident with casts on her arms but was unable to answer other questions.

Record review indicated a Social Services note from 07/28/21 at 2:10 PM that Resident #328 was discharged home with daughter. The resident was to have home health nursing at home.

Resident #328 was discharged on 07/28/21 before the wound consult was done.

Resident #328 was readmitted to the hospital the following day on 07/29/21 with severe right heel pain. Her white blood cell count was 16.4. Blood cultures completed on 07/29/21 were positive for bacteria and revealed Proteus Mirabilis.

Review of hospital records from 07/29/21-08/16/21 indicated Resident #328 had bacteremia (infection of the blood) related to the pressure ulcer. The pressure ulcer on hospital admission was described as very red and swollen and measured 3.0 centimeter (cm) x 3.0 cm with overlying black eschar (dead tissue). The

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resident underwent right heel wound debridement on 08/07/21.

A phone interview with Nurse Practitioner (NP) #1 on 02/01/22 at 12:09 PM regarding Resident #328's pressure ulcer was done. She stated the pressure ulcer was avoidable, and she didn't recall how the staff were helping her with the bed mobility, but she should not get a pressure ulcer. She said she would have expected more skin assessments between her admission and the day of the pressure ulcer discovery. In addition, that if they noticed redness, they should have floated her heels for prevention.

A phone interview was conducted with the Director of Nursing (DON) on 02/01/22 at 2:10 PM regarding pressure ulcers. She noted that following the previous concerns with pressure ulcers, they had done extensive education in September 2021 and ongoing audits and monitoring for the prevention and treatment of pressure ulcers. She stated they do a full body assessment on admission, and then a weekly assessment by the floor nurse. She was asked about the skin protocol for skin observation daily for 3 days of any new areas and said this was documented with ADL care and any changes are noted in the record. The DON was asked how skin assessments and preventative treatments were communicated to staff, and stated it was on task record for nurses and NA's and staff were trained to report any skin changes during their care. The DON was asked how this information was communicated to agency personnel and stated in the electronic medical record they see the interventions as PRN (as needed) tasks for both the nurses and nurse assistants (NA). She was asked about prevention for pressure ulcers

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and stated they evaluate the pressure ulcer risk with a skin assessment scale on admission, and weekly for 4 weeks. She noted if the resident was at a medium or high risk, then they were discussed at the Interdisciplinary Team (IDT) daily clinical meeting which met Monday through Friday and discussed at the weekly risk IDT meeting. She stated if interventions were identified they were listed on the care plan. She noted normally the MDS nurse did the care plan updates but she had updated care plans as well and usually they were updated during the IDT meetings.

The facility provided the following corrective action plan with a completion date of 09/30/21.

Inservices were done for pressure ulcer prevention, skin assessment, treatment and services to heal pressure ulcers and staff and agency attendance roster sheets were provided. The education was completed on 09/29/21.

09/17/21, licensed nurses completed skin assessments for 62 recurrent in-house residents. Residents identified with skin concerns were reviewed for associated treatment orders and documentation of treatments on the TAR. The physician was notified by the licensed nurse of newly identified skin concerns and treatment orders obtained and care plan updated to reflect associated care and interventions to prevent and/or heal pressure wounds.

-Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

09/17/21-09/27/21, the DON, MDS Coordinator

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and or Nurse supervisor provided education to licensed nurses including agency nurses on facility guidelines for pressure ulcer prevention and management. Education includes completing resident skin assessments, notification of changes in skin condition, obtaining treatment orders, updating and revising care plans and documenting completion of treatments as ordered to prevent and heal pressure wounds.

09/17/21-09/27/21 The DON, MDS Coordinator and Nurse Supervisor provided education to nurse aides including agency aids on facility guidelines for completing skin observations and reporting resident skin changes to supervising licensed nurse.

Education includes use of Body Scan Tools and Point Click Care (PCC) Clinical Alerts to communicate skin concerns observed during ADL care. Newly hired licensed nurses and nurse aides will receive education during orientation. Going forward new agency staff will be educated prior to working their next scheduled shift.

The licensed nurse will complete resident skin reviews upon admission, weekly and with changes in skin condition to identify skin concerns. The nurse aide will complete skin observations during bathing and routine ADL care to identify skin concerns and communicate such findings to the licensed nurse. The licensed nurse will notify the physician and/or nurse practitioner of new skin concerns and implement treatments as ordered. Treatments will be completed and documented on the TAR by the licensed nurse as ordered. Care plans to prevent and/or heal pressure wounds will be initiated upon new findings and reviewed and revised by

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the IDT with changes in skin condition and associated treatments. Pressure and non-pressure will be assessed by the licensed nurse upon finding, weekly and with changes in condition and documented in PCC on the Pressure/Non-Pressure Ulcer UDA tool. The Director of Nursing and Wound Nurse will monitor the TAR daily for completion of treatments as ordered and will monitor residents with skin concerns for compliance with pressure ulcer management and prevention during daily clinical meetings for new skin concerns and weekly during risk meetings.

The DON, MDS Coordinator and or Nurse Supervisor will complete an audit of resident assessments, notification to practitioner, associated treatment orders, TAR and care plan. Monitoring will be completed for 5 random residents at a frequency of 5 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assessment Process Improvement (QAPI) meetings monthly for 3 months and will make changes to the plan as necessary to maintain compliance with treatment to prevent and heal pressure wounds.

-Include dates when corrective action will be completed. Education would be completed by 09/29/21 of current staff and agency staff. Ongoing education was done for new staff and new agency staff.

Review was completed of audits for prevention and treatment to heal pressure ulcers which were completed 09/27/21-12/29/21.

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F 686	Continued From page 47 Review was done of the QAPI meeting minutes when pressure ulcer audits for prevention and treatment to heal pressure ulcer were reviewed. -All actions were completed by: Validation of the correction action plan was on 10/27/21 during an onsite follow-up to a pressure sore citation. Based on the validation of the corrective action plan F 686 was corrected on 09/30/21.	F 686		
F 689 SS=J	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to safely execute the use of a shower gurney with side rails that included pins to hold the side rails in place which resulted in Resident #74 falling from the shower gurney when the side rail did not remain in place. Resident #74 was diagnosed with three post-traumatic fractures of the right and left legs that required surgical repair. Accident hazards were reviewed for 1 of 2 residents reviewed (Resident #74).	F 689	Past noncompliance: no plan of correction required.	3/4/22

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Findings included:

Resident #74 was admitted to the facility on 1/20/20 with the diagnoses of pain and osteoarthritis.

Resident #74's quarterly Minimum Data Set dated 9/23/21 documented she had no memory problems. The resident required extensive assistance of 2 staff for transfer and was dependent for bathing. The resident's weight was 248 pounds.

Resident #74's care plan dated 9/24/21 documented she was at risk for falls and fall related injuries due to an impaired balance and was dependent on staff for transfers. Interventions included to anticipate and meet the resident's needs and side rails as ordered. The resident required assistance with self-care needs related to disease process and generalized weakness. Interventions included offer shower twice a week and as needed, one staff to assist with bathing, dressing and grooming, and side rails to remain on bed to assist with self-positioning while in bed per resident request.

A nurses' note dated 11/10/21 documented Nurse #1 was "notified by staff (NA #4) at 7:41 am that Resident #74 had fallen in the shower room and that the resident was on the floor. Upon arrival to the shower room, resident was seen laying on the floor on her back in the shower. At this time, the shower stretcher was noted in the hallway. I was informed by nursing staff that Emergency Medical Service (EMS) had already been called to transport the resident to the emergency room for evaluation and treatment as indicated. When asked what happened, Resident #74 stated that

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she fell from the shower bed. The resident noted to be yelling out in pain and reported pain 10/10 scale at this time in her bilateral lower legs "from the waist down" and that the left was greater than the right. The resident was asked if there was any specific area that hurt specifically, and she stated her whole lower half but the left ankle specifically. The resident was asked if she could wiggle her toes, and the resident was able to wiggle her toes on both feet without increased pain. Nurse was unable to further assess the resident ' s range of motion due to level of pain. Nurse #1 requested staff at the nursing station call for EMS and remained with the resident. Nurse #1 went at this time to retrieve the resident ' s as needed pain medication per her request. EMS arrived and further assessed the resident. EMS stated to hold off and that they would administer pain medication once they were in the ambulance to manage her pain. The resident remained on the floor until assessed further by EMS, at which time the resident was mechanically lifted to the stretcher. The resident left the facility by ambulance with EMS at approximately 8 am to be transported to the emergency room."

On 1/26/22 at 3:00 pm an interview was conducted with Nurse #1. Nurse #1 stated she was called to the shower room by Nursing Assistant (NA) #4 when Resident #74 fell off the shower gurney. The resident was found on the floor next to the gurney in pain. EMS was called. Nurse #1 interviewed NA #4 (agency) who stated she was showering the resident on the gurney when the resident slid off. The rail had a pin which did not hold the resident on the gurney. Nurse #1 stated that she would place towels on the gurney to prevent slipping and use the rail. Nurse #1 state that NA #4 had given her two

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different accounts of what happened. The rail broke and the rail was not used. Nurse #1 stated she interviewed the resident who informed the nurse that NA #4 was rushing, and the gurney was not up against the wall for stability with NA #4 on the other side to prevent falling. Nurse #1 stated that the information NA #4 gave her sounded like the side rails were not used. The resident informed Nurse #1 this was how it was normally done (shower on a gurney). Nurse #1 stated that this was the second day for NA #4, and she was terminated. Nurse #1 stated that there was nursing in-service for use of the new gurney function, showering, transfer, and safety immediately after the incident on 11/13/21.

According to the hospital discharge summary she moved to another facility after treatment at the hospital.

On 2/7/22 at 1:34 pm a telephone interview was conducted with Resident #74. Resident #74 stated that NA #4 gave her a shower on the gurney. She preferred the gurney because of back pain. She stated that both side rails were up on the gurney. Resident #74 stated she used the side rail on the NA ' s side and it was secure, but when she grabbed the side rail on the other side, it gave way as if it was not secured. She stated she did not think it had broken. Resident #74 stated she had never had a problem receiving her shower before. This incident was isolated to this one, new NA #4. The side rails were always secure with other staff and there was never a problem. Resident #74 stated that NA #4 was rushing. Resident #74 stated that the fracture to her left leg had plate and screws to hold the bone together which caused her pain and was presently unable to bear weight on her

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left leg.

On 1/26/22 at 11:15 am an interview was attempted with NA #4 and her phone number was no longer in service.

Resident #74's hospital discharge summary dated 11/25/21 documented the resident was brought to the hospital from the nursing home after a fall. The Emergency Department Physician documented on 11/10/21 the resident informed him "they dropped me from the shower bed." The resident sustained three post traumatic fractures of the left and right legs. The resident informed the physician that the handle she "was holding gave way and did not believe it was a mechanical failure." The plan was for orthopedic surgery. Preoperative diagnoses were right one third femur shaft fracture, left peri-prosthetic femur fracture, left distal metaphyseal tibia fracture, and osteoporosis. The procedure performed was closed management of left peri-prosthetic of distal fracture, closed management of left distal one third tibial fracture, and operative fixation of periprosthetic femur fracture with nail plate construct. Pain level was 8 out of 10. The resident was discharged to another nursing home with no weight bearing on both legs to receive physical and occupational therapy.

On 01/26/22 at 11:36 am an interview was conducted with the Maintenance Director. The Maintenance Directed stated he remembered Resident #74 and when she fell. The shower gurney side rail was down and the pins that held the rail up could not be found and were not used. Without the pins, the rail would not remain up to support a resident. The gurney siderails were not

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safe to use without the pins. The staff were aware that the side rails required pins. The pins were observed on weekly rounds before the resident's fall. The Maintenance Director stated that there were two types of shower gurneys. One type that required a pin to hold the rail and another type where the rail was secured within the gurney. The Maintenance Director stated he observed the gurney that required the pin, and it was used with the side rail down and the resident fell out of the gurney onto the shower room floor. The pins to hold the side rail were not in place and this was the first time he had observed missing pins. The shower gurney that required pins to hold the side rail up was replaced with gurneys that do not require pins but had side rails enforcement that were part of the gurney. The quality assurance evaluation that the gurney was not properly used was documented, and audits were completed ongoing of the shower equipment each week by Maintenance. Concurrent observation of documented shower equipment checks for working order logs were provided.

On 1/27/22 at 2:30 pm an interview was conducted with the Director of Nursing (DON). She described actions the facility took to correct the problem. She stated that the accidental fall on 11/10/21 with Resident #74 was caused by the improper use of the gurney. The improper use was failure to use pins to secure the side rail. NA #4 was agency staff, new on her second day of employment, and was no longer allowed to work for the organization. All agency nursing staff were required to read and sign an attestation for proper facility equipment usage and if there was a lack of understanding the nurse was required to obtain assistance. A root cause analysis was

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completed (improper use of gurney) and presented to the quality assurance team. The gurney was discarded, and a new type of gurney was purchased that do not require pins to hold the side rail. The side rail secured as part of the gurney frame. There were no additional pieces. All nursing staff were in-serviced on the proper usage of the new shower gurney with return demonstration, fall prevention and shower safety, and transfer. Documented attendance roster sheets were provided.

The facility provided the following corrective action plan with a completion date of 11/19/21.

·Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The accidental fall on 11/10/21 with Resident #74 was caused by the improper use of the shower gurney. There was failure to use required metal pins to secure the side rail. Resident #74 was sent to the emergency room and subsequently did not return to the facility. A root cause analysis was completed by the Director of Nursing on 11/10/21, and cause was identified as improper use of the gurney side rail. High-risk fall investigation was completed. The outcome investigation was submitted to quality assurance on 11/11/21. Quality assurance directed the Maintenance Director to audit the proper working function of the shower gurneys 11/11/21. The Maintenance Director found that the pins were missing for the gurney used for Resident #74 and the other type of gurneys were working as manufacturer expected.

·Address how the facility will identify other

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residents having the potential to be affected by the same deficient practice;

The gurney that required a pin to secure the side rail was discarded on 11/11/21. There were polyvinyl chloride (PVC) gurneys in the facility on 11/11/21. This type of gurney that did not require a pin to secure the side rail. It was used for education and return demonstration and additional PVC type gurneys were purchased/ordered immediately (11/11/21) and obtained within a week. All nursing staff, including agency staff, were in-serviced on 11/10/21 through 11/17/21 for the proper usage of the PVC type shower gurney with return demonstration, fall prevention and shower safety, and transfer by the Director of Nursing. The deficient practice was isolated to one gurney that required a pin and an agency nursing assistant that was not familiar with the one gurney that required a pin to secure the side rail. That nursing assistant no longer worked at the facility. Observation of nursing staff use of the shower gurney to provide resident showers began on 11/15/21 was documented three times a week. No concerns of correct usage were identified.

·Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

All nursing staff, including agency, were required to provide return demonstration to the Director of Nursing of the PVC type shower gurney use and participate in in-service for showering residents, transfer, falls, and safety from 11/10/21 through 11/17/21. Audits were documented of shower gurney use with the resident by the Director of Nursing (DON) which began on 11/15/21 for three

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times a week. All agency staff are required to read and sign an attestation that they have experience with the facility equipment or ask for assistance.
Weekly audits of shower equipment function/operation were documented and are ongoing to the present by the Maintenance Director which started 11/11/21. Audits are presented to quality assurance by the Maintenance Director to assure shower gurneys were in proper working order.

The results of the monitoring/audits were presented by the DON in an ad hoc meeting to the Quality Assurance members on 11/11/21 to address the Resident #74's fall and again at each of the regularly scheduled meetings each month to evaluate the plan was sustained. The QAPI team reviewed the audits, and no changes were made to the plan. There were no further fall incidents with use of the shower gurney. The results of this monitor were ongoing and presented to the QAPI team by the DON.

·Include dates when corrective action will be completed.

All actions were competed by 11/17/21 including education and return demonstration was completed. Additional gurneys were obtained by 11/19/21. Observation of nursing staff use of the shower gurney with the resident present began on 11/15/21 three times a week and was ongoing.

Validation of the correction action plan was on 1/27/22.

On 1/26/22 at 11:55 am an observation was done of the shower gurneys. The shower gurney that

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F 689	Continued From page 56 required pins to hold the side rails was not present in the facility. The current gurneys had side rails that were secured within the gurney. Pins or other unconnected pieces were not required to secure the side rails. Side rails were tested and were operating as intended. On 1/27/22 at 3:00 pm an interview was conducted with Nurse #1. She stated that all nursing staff, including agency were required to participate in in-service for shower gurney use, safety, falls, and return demonstration. "We also participated in shower and transfer safety in-service and were required to sign a roster." On 1/27/22 at 3:30 pm random interviews of 3 NAs revealed that they were aware of the resident fall from the shower gurney, that the gurney with required pins was discarded, additional PVC gurneys were obtained, and participated in in-service. The facility corrected accident/hazards by 11/19/21 after completion of in-service, return demonstration of shower gurney use, and receipt of new PVC gurney. Based on the validation of the corrective action plan F 689 was corrected 11/20/21.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		3/11/22

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F 725	Continued From page 57 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview of with the staff and residents and physician, the facility failed to provide sufficient nursing staff to meet the needs of dependent residents for incontinence care. (Resident #'s 4, 5, and 374) for 3 of 8 residents sampled. The findings included: Cross referred: F677: Based on observation, record review and interview of the staff, residents, and family member, the facility failed to provide incontinence care to residents that were dependent for activities of daily living for 3 of 8 residents (Resident #'s 4, 5, and 374).	F 725	The facility failed to provide sufficient nursing staff to meet the needs of dependent residents for incontinence care for 3 of 8 residents sampled (Residents #4, #5, and #374). Incontinence care was provided at the time the delay was brought to the attention of the staff for Residents #4, #5, and #374 on Wednesday 1/26/2022. Staffing schedules were reviewed by the Interim Director of Nursing and the Administrator when the facility was made aware of the delay. An audit of residents listed as dependent	

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F 725	Continued From page 58 On 1/26/22 at 11:00 am an observation was done of NA #1 provide incontinence care. The NA was having difficulty turning Resident #4 alone and stopped to go get assistance. The NA returned and stated there was no help at this time. The NA turned the resident to the other side and had the resident hold the side rail to wash her back. The resident commented "there was never any help." On 1/26/22 11:55 am an interview was conducted with the Maintenance Director. He stated that he was aware there was a nursing staff shortage. He came to the facility during inclement weather on the weekend to assist with passing meal trays and other assistance as needed due to a lack of nursing staff. On 1/26/22 at 3:15 pm an interview was conducted with the facility physician. He was aware that there was a nursing shortage, and that management was providing care. He stated that there was a nursing shortage all over (other facilities). On 1/26/22 at 3:00 pm an interview was conducted with Nurse #1. She stated that there was a nursing staff shortage. Today on day shift there were 3 NAs working and the total should be 8 for days, 6 for evenings, and 4 for nights. On 1/27/22 at 5:00 pm an interview was conducted with the Administrator and DON. The Administrator stated that because of the COVID outbreak on Wednesday 1/26/22, nursing staff were pulled to create a COVID unit and staff moved COVID positive residents and their belongings to the unit. The Administrator stated	F 725	for incontinence care on Minimum Data Set (MDS) Section H and have a Brief Interview for Mental Status (BIMS) of 11 or higher will be interviewed by the Director of Social Services regarding the timeliness of their incontinence care. Interviews will be completed on or before Friday March 11, 2022. Any identified concerns will be brought to the Director of Nursing and addressed at that time. Incontinent residents with a BIMS of 10 or below will be rounded on by the Staff Development Coordinator (SDC) and/or Unit Manager and will be observed for signs of urine/feces odors, excessive soiling, and/or skin breakdown. This audit will be complete on or before Friday March 11, 2022. Any identified concerns will be brought to the Director of Nursing and addressed at that time. The Administrator and/or Director of Nursing will educate the Staff Development Coordinator and Staff Scheduler on sufficient staffing needs and to notify the Administrator and/or Director of Nursing if needs are not met due to staff absences or open positions on the schedule. Education will be completed on or before Friday March 11, 2022. The Staff Scheduler will submit nursing staff schedules to the Administrator and Director of Nursing for review and approval prior to posting the master or daily schedules. The Administrator and/or Director of Nursing will initial the Master and/or Daily schedules verifying approval	

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F 725	Continued From page 59 the incontinence care delay provided to residents was isolated. The Administrator stated that 5 residents tested positive on Wednesday, and she already had staff out who tested positive for COVID last week. The Administrator stated this was a crisis, and she had the option to use COVID positive staff that received the COVID vaccine and were asymptomatic but decided not to use that staff because she felt it could make matters worse. The Administrator stated that her emergency plan was to use a nurse agency for staffing shortage but there was limited availability during the COVID increase. DON stated, there just wasn't any staff.	F 725	prior to posting of daily schedules. The facility will continue to post open full-time positions for licensed nurses and certified nursing assistants to available job boards as appropriate. Interviews will be conducted with prospective employees as soon as able to be scheduled after application is received. The Director of Nursing (DON), Staff Development Coordinator (SDC) and/or designee will conduct an audit of incontinence care to dependent residents and ensure sufficient nursing staff on the floor to meet the needs of residents. Audits will be completed five (5) times weekly for four (4) weeks, then three (3) times weekly for three (3) weeks, then weekly for four (4) weeks or until 100% compliance is achieved and maintained. The Administrator and/or designee will review these audits for compliance on a weekly basis. The Administrator and/or designee will bring results of audits to monthly QAPI meeting for review with the interdisciplinary team (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100% compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		3/11/22

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F 732	Continued From page 60 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff	F 732	The facility failed to post accurate staffing	

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F 732	Continued From page 61 interviews, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 5 of 7 posted daily staffing forms reviewed. Findings included: Daily staffing forms for 11/22/2021, 11/23/2021, 12/29/2021, 12/30/2021, 12/31/2021, 1/4/2022, and 1/5/2022 were reviewed and revealed the following were not accurate on 5 of 7 dates: a. The nurse schedule for 11/22/2021 had 4 nursing assistants (NA) scheduled to work the afternoon shift (3:00 PM to 11:00 PM). The posted daily staffing form indicated 6 NAs provided 38 hours of care on that date. The nurse schedule for night shift (11:00 PM to 7:00 AM) had 4 NAs scheduled to work that date. The posted daily staffing form indicated 6 NAs had provided 38 hours of care on 11/22/2021 during night shift. b. The nurse schedule for 12/29/2021 had 9 NAs scheduled to work the day shift (7:00 AM to 3:00 PM). The posted daily staffing form indicated 10 NAs had provided 75 hours of care on that date. The nurse schedule for afternoon shift on 12/29/2021 had 7.5 NAs scheduled to work afternoon shift. The posted daily staffing form indicated 8 NAs had provided 60 hours of care that shift. c. The nurse schedule for 12/30/2021 afternoon shift had 5.5 NAs scheduled to work. The posted daily staffing form indicated 6 NAs had provided 41 hours of care that shift. The nurse schedule for 12/30/2021 did not have a Registered Nurse (RN) scheduled to work night shift on 12/30/2021.	F 732	information for licensed and unlicensed nursing staff for 5 of 7 posted daily staffing forms reviewed. Staff postings were checked for accuracy when facility was made aware of inaccuracies. No residents were affected by deficient practice. The Staff Development Coordinator (SDC) will educate the scheduler one on one regarding the Posted Nurse Staffing, including the need for accuracy of posting and updating the posting as changes occur with the schedule and to the facility□s resident census on 3/11/2022. The SDC will educate Business Office Manager, Social Services Director, Admissions Coordinator, Activities Director, receptionists, and current facility and agency licensed nurses regarding the Posted Nurse Staffing, including the need for accuracy of posting and updating the posting as changes occur with the schedule and to the facility□s resident census on 3/11/2022. Newly hired Business Office Manager, Social Services Director, Admissions Coordinator, Activities Director, receptionists, and current facility and agency licensed nurses will be educated upon hire. The Staff Development Coordinator, Director of Nursing, or Administrator will complete a review of the posted nurse staffing daily for accuracy and make changes as indicated Monday through Friday for a period of four (4) weeks, then three (3) times weekly for four (4) weeks, then weekly for four (4) weeks, or until	

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F 732	Continued From page 62 The posted daily staffing form indicated 1 RN provided 8 hours of care that shift. d. The nurse schedule for 12/31/2021 had 2.5 RNs scheduled to work the day shift. The posted daily staffing form indicated that 2 RNs had provided 16 hours of care. The nursing schedule for evening shift on 12/31/2021 had 1.5 NAs scheduled to work. The posted daily staffing form indicated 2 NAs had provided 11.5 hours of care. e. The nurse schedule for 1/5/2022 had 1.5 RNs scheduled to work. The daily posted staffing form indicated 1 RN had provided 8 hours of care. The nurse schedule had 5 NAs scheduled to work afternoon shift. The posted daily staffing form indicated 6 NAs had provided 37 hours of care that shift. The nurse schedule for night shift on 1/5/2022 had 5 NAs scheduled to work. The posted daily staffing form indicated 6 NAs had provided 45 hours of care that shift. The facility scheduler was interviewed on 1/27/2022 at 12:30 PM. The scheduler reported she was correcting posted daily staffing forms during the day shift and afternoon shift. The scheduler explained that the front desk receptionist worked until 8:00 PM and she would make corrections in the evening. The scheduler reported the facility was using agency staff to fill open positions for all three shifts. The scheduler explained a phone app was used by the agency staff to pick up shifts, and if the agency staff used the app to call out sick, the facility was not notified of the absence. The scheduler reported when a call out happened, either she or the receptionist would modify the posted daily staffing form. The scheduler concluded by explaining the weekend supervisor worked from 11:00 AM to 11:00 PM	F 732	substantial compliance is achieved and maintained. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance Accurate Nurse staff posting. Completion Date: 3/11/2022	

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F 732	Continued From page 63 and she was not aware the RN should have her hours credited on both day and afternoon shifts. The Director of Nursing (DON) was interviewed on 1/28/2021 at 11:54 AM. The DON reported the posted daily staffing form should be updated by the scheduler, the receptionist, the DON, or the charge nurse on afternoon and night shifts. The DON reported she expected the posted daily staffing form to accurately reflect the staffing of licensed and unlicensed staff working in the facility for each day.	F 732		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		3/11/22

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F 803	Continued From page 64 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to serve chicken pot pie in the portion required by the menu to 11 of 11 residents observed. (Residents #5, 15, 18, 35, 58, 60, 64, 70, 71, 175 and 176). This deficient practice had the potential to affect other residents. The findings included: An observation of the lunch meal tray line occurred on 01/27/22 at 12:10 PM. Cook #1 was observed plating chicken pot pie using a #8 (4 ounce) utensil to 3 residents. Four plates with chicken pot pie for residents were observed on the top of the steam table, plates were covered by dietary staff and placed in an insulated delivery cart. There were four plates for residents observed already in the insulated delivery cart. The lunch meal tray tickets revealed chicken pot pie was to be served in a portion recorded as "1 each" to residents. Interview with Cook #1 at the time of the observation revealed she had already plated chicken pot pie for delivery to 11 residents. Cook #1 stated she was not sure what a serving of "1 each" was equivalent to and stated, "Since the tray ticket just says one each, I just used a regular serving scoop." Cook #1 verified that the serving utensil she used was a 4-ounce utensil and stated that she did not ask her manager for clarification regarding the portion of chicken pot pie to serve.	F 803	Facility failed to follow menu regarding portion size. Newley hired Certified Dietary Manger will be educated by Regional Dietary Manager and then the Dietary manager will educate dietary staff regarding following recipe recommendation and portion size. Education will be added to new hire orientation. This education will be completed by 3/11/2022. Certified Dietary Manager will audit the recipe and recommendations for portion size. This audit will be conducted 5 x per week for 4 weeks and then 3 x a week for 4 weeks and then 2 x a week until the facility achieves compliance. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly. At that time, the QAPI committee will evaluate the effectiveness is continued auditing is necessary to maintain compliance. The Administrator and the Certified Dietary is responsible for this plan. Completion date: 3/11/22	

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F 803	Continued From page 65	F 803		

Review of the recipe, Chicken Pot Pie, revealed the recipe was to be portioned evenly into 12 inches, by 20 inches by 4 inches pans for 30 portions per pan. The recipe yield was 65 total servings, and the portion size was recorded as 30 servings of 2 inches by 4 inches per full pan. Review of the recipe revealed the total ingredients would yield approximately 485 ounces and 65 portions would yield approximately 7.46 ounces each. The pan used by Cook #1 to portion the chicken pot pie into was measured as 2.5 inches in depth.

An interview with the certified dietary manager (CDM) occurred on 01/27/22 at 12:10 PM and revealed he was not aware of the serving utensil Cook #1 used to serve the chicken pot pie. The CDM reviewed the recipe during the interview and stated the recipe recorded the serving size as a 2 inch by 4 inch serving and that each pan should yield approximately 30 servings. He stated he did not notice that the chicken pot pie recipe recorded a pan that was 4 inches in depth as the correct size pan to use. The CDM further stated that he would expect the cook to use the correct size pan and to cut the chicken pot pie into 2 inches by 4-inch portions per the instructions to ensure each resident received the correct portion of vegetables and meat.

A follow up interview occurred on 01/27/22 at 1:36 PM with Cook #1. The interview revealed Cook #1 added diced frozen chicken to canned mixed vegetables. Then Cook #2 added the cream of chicken soup to the chicken mixture, layered the pan with a crust, poured the chicken mixture over the bottom crust and then topped the pot pie with another crust. Cook #1 stated she divided the mixture between 2 pans that were 2.5 inches

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F 803	Continued From page 66	F 803		

deep and placed the pot pies into the oven to bake. Cook #1 stated she did not notice that the recipe required use of a pan that was 4 inches in depth. She stated that she did not refer to the recipe when she prepared the chicken pot pie because Cook #2 helped her to prepare the recipe.

An interview with Cook #2 (lead cook) occurred on 01/27/22 at 01:40 PM. Cook #2 stated she helped Cook #1 prepare the chicken pot pies, but that she did not review the recipe. Cook #2 stated she had prepared the chicken pot pie recipe many times and that she was familiar with how to prepare it. Cook #2 stated she layered each pan of chicken pot pie with a bottom crust, added cream of chicken soup to the chicken mixture, Cook #1 added the chicken mixture to the pans and then Cook #2 topped each pot pie with a crust. Cook #2 stated she added the additional bottom crust to make the recipe better.

The consultant registered dietitian (RD) was interviewed by phone on 1/27/22 at 2:40 PM. The RD stated in interview that she provided clinical support to the facility and that the CDM also had a corporate RD for contact. The RD stated in interview that casseroles that provided both a vegetable and a protein were typically served in a 6-ounce portion. The RD stated that she would expect the residents to receive a portion of chicken pot pie according to the menu. The RD also stated that if the Cook did not use the correct size pan but put the whole recipe into one pan and the yield was 30 portions, the residents would have received a correct portion, but if the Cook divided the recipe and used the wrong size pan, the portion size would have to be adjusted to ensure each resident received a 4 ounce portion

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F 803	Continued From page 67 of vegetable and 2 ounce portion of meat. The administrator was interviewed on 01/27/22 at 03:50 PM and reviewed the chicken pot pie recipe during the interview. The administrator stated she expected dietary staff to follow the recipe, use the correct size pan and serve the portion per the recipe to get the correct yield and to give residents the correct portion.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to 1) thaw a potentially hazardous food with an effective food safety system, and 2) store cold/frozen foods sealed and with a label and date of opening. The	F 812	Facility failed to 1) thaw a potentially hazardous food 93.4 degrees Fahrenheit. 2) label, date and properly seal food items when opened. All food items improperly thawed and stored in refrigeration and left	3/11/22

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F 812	Continued From page 68 facility thawed frozen diced ham, that was not submerged, under running water with a temperature of 93.4 degrees Fahrenheit (F). The facility stored hot dogs, sliced ham, sliced turkey, French fries, pancakes, sliced cheese and chicken tenders without a label and date of opening and open to air. This failure occurred in 2 of 3 cold storage units and had the potential to affect food served to residents. The findings included: 1. An observation occurred on 01/27/22 at 12:10 PM of a sealed plastic bag of frozen diced ham stored in a large pot filled with water. Both the cold and hot water faucets were turned on with water running into the pot. The top portion of the bag of ham was not submerged in the water. Review of the menu for 01/27/22 at 12:11 PM revealed ham and potato casserole was to be served for the dinner meal. Temperature monitoring on 01/27/22 at 12:12 PM by the certified dietary manager (CDM) revealed the following: ·The water in the pot was 90.3 degrees F ·The running water was 93.4 degrees F ·The diced ham was 27.4 degrees F During an interview on 01/27/22 at 12:15 PM the CDM stated he did not know who set up the pot of running water to thaw the diced ham. Cook #1 (morning cook) was interviewed on 01/27/22 at 12:16 PM and stated she observed the CDM set up the pot of running water to thaw the diced ham.	F 812	open to air, and thise without date and label upon opening were disposed of during survey findings on 1/24/22 and 1/27/22 by cooks. Newly hired Certified Dietary Manger will be educated by Regional Dietary Manager and then the Dietary Manager will educate dietary staff on label and dating opened items including thawing items at appropriate temperatures based on manufacturer recommendations. Education will be added to new hire orientation. These educations will be completed by 3/11/2022. Certified Dietary Manager will audit the kitchen to ensure that open items are dated and labeled, to ensure that items are not being left open to air, and to ensure that meat is being thawed at appropriate temperatures. This audit will be conducted 5 x per week for 4 weeks and then 3 x a week for 4 weeks and then 2 x a week until the facility achieves compliance. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly. At that time, the QAPI committee will evaluate the effectiveness is continued auditing is necessary to maintain compliance. The Administrator and the Certified Dietary Manager are responsible.	

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F 812	Continued From page 69	F 812		

The CDM stated in a follow up interview on 01/27/22 at 12:17 PM that he wanted to clarify his previous interview. He stated that about 30 minutes ago, he put the plastic bag of diced frozen ham in a pot to thaw and turned on the cold water. He stated he could not explain why the hot water faucet was also turned on. The CDM stated that he was trying to thaw the frozen ham in time to use it to prepare the ham and potato casserole that would be served for the dinner meal. The CDM further stated that the frozen ham should have been submerged in cold water with water at least 70 degrees F, running into the pot.

An interview with the administrator on 01/27/22 at 3:50 PM revealed she expected dietary staff to thaw frozen meats using a safe thawing method.

2a. The walk-in refrigerator was observed on 01/24/22 at 11:20 AM with the following:
·An opened plastic bag of hot dogs stored without a label to record the open date
·An opened plastic container of deli ham stored without a label to record the open date
·An opened plastic container of sliced turkey stored without a label to record the open date

2b. The freezer was observed on 01/24/22 at 11:35 AM with the following:
·A bag of French fries was stored open to air and without a label to record the open date
·A plastic bag of pancakes with an open date of 01/14/22 was stored open to air
·A bag of chicken tenders was stored open to air and without a label to record the open date

2c. The reach in refrigerator was observed on 01/24/22 at 11:40 with sliced American cheese

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	345130	A. BUILDING _____ B. WING _____	C 02/14/2022

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ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

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F 812	Continued From page 70 with an open date of 01/19/22 stored open to air. An interview with Cook #2 occurred on 01/24/22 at 11:45 AM and revealed she stored items in the walk-in refrigerator and the freezer that she forgot to label before putting them away. An interview with the CDM on 01/24/22 at 11:46 AM revealed he expected staff to label foods after opening with the date opened and store all foods in sealed containers. He stated that dietary staff were expected to round daily prior to starting their shift to monitor refrigeration units for unlabeled, undated foods or foods stored open to air. He stated that it was the responsibility of the cooks to monitor refrigeration units and that he provided oversight. The CDM stated these items were missed when staff monitored cold storage that day. An interview with the administrator on 01/27/22 at 3:50 PM revealed she expected dietary staff to label, date and seal all foods before storage.	F 812		
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. §483.70(i)(1) In accordance with accepted	F 842		3/11/22

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F 842	Continued From page 71	F 842		

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 legal age under State law.

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F 842	Continued From page 72 §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 observations, record review, family, nurse practitioner and staff interviews, the facility failed to accurately document the resident's cognition (Resident #328) for 1 of 1 resident reviewed for accuracy of medical record. The findings included: Resident #328 was admitted to the facility on 07/21/21 from the hospital. The admission assessment completed on 07/21/21 at 14:27 PM indicated Resident #328 was oriented to person, place, time and situation. The Nurse Practitioner (NP) Day 1 progress note dated 7/22/21 revealed Resident #328 had normal cognition, was oriented to date, time and place. Record Review indicated a NP note from 07/26/21 for the 3 day post admission follow up with past medical history of fracture of multiple ribs (left side 2-10), MVA, ankle joint pain and	F 842	The facility failed to accurately document the resident's cognition (Resident #328) for 1 of 1 resident reviewed for accuracy of medical record. Documenting Nurse Practitioner was notified of the error in documentation and addendum progress note was dictated and uploaded by Nurse Practitioner on 3/11/2022. All residents are at risk to be affected by inaccurate cognition documentation by medical provider. An audit of the most recent uploaded medical provider dictation to ensure the documentation of cognition level matches facility assessed BIMS cognition level. Inaccuracies will be reported to Medical Director for correction. Audit and corrections will be completed by 3/11/2022. Director of Nursing and Administrator will provide education to medical providers on ensuring correct cognition levels are	

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bilateral hand fractures. Resident #328 was noted to be a poor historian due to cognitive/psychiatric impairment and the cognitive status documented was unable to assess/dementia. Resident was noted to be awake, alert and cooperative.

The care plan identified a care area for Resident #328 initiated on 07/26/21 of impaired cognitive function/dementia or impaired thought processes r/t head injury, impaired decision making.

The Admission Minimum Data Set (MDS) assessment completed on 07/28/21 indicated Resident #328 was cognitively intact. Her Brief Interview for Mental Status score was 15 (15 is normal cognition).

Record review of the NP discharge note dated 07/27/21 noted Resident #328 was a poor historian due to cognitive/psychiatric impairment. She was noted to be alert and oriented to person, place and time with normal cognition.

NA #6 that cared for Resident #328 on 07/22/21, 07/23/21, 07/24/21, 7/25/21 and 07/27/21was interviewed via phone on 01/28/22 at 1:04 PM. She recalled the resident well. The NA was asked about any decrease in her level of consciousness and said she was "always very alert, in her right mind and would call out phone numbers to her to dial."

The Nurse Practitioner was interviewed via phone on 02/01/22 at 12:09 PM regarding Resident #328. She was asked about the resident's cognitive status and stated she did not recall the resident but reviewed her notes. The NP was asked about the cognitive/psychiatric notation on

dictated and transcribed into the resident□s electronic medical record. Education will be completed by 3/11/2022.

The Medical Records Clerk will review the medical provider documentation on cognitive levels prior to uploading the information into the electronic health record to ensure that the documentation is consistent to prior progress notes or medical provider dictation. Inaccuracies will be brought to the Director of Nursing to follow up on prior to upload into the system. Data collected during reviews by medical records will be given to Administrator on a weekly basis for 12 weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance of Accurate cognition documented by medical provider in Resident Records.

Completion Date: 3/11/2022

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the three assessments she had documented. She stated she did not recall why she wrote the cognitive change but stated it could have been an error as she did not see anything to support the dementia. She noted it was probably a click in the medical record and could have been something was carried over from someone else's documentation. The NP also questioned if maybe the resident was sleeping. She reviewed the hospital pre-admission notes during the interview. She was informed the resident had Brief Interview of Mental Assessment (BIMS) of 15 on the admission MDS assessment and a Glasgow Coma Score (neurological assessment-15 is within normal limits) of 15 at the hospital on the History and Physical report prior to admission. The NP stated she could not comment on the cognition from 7/26/21 as she not sure after she reviewed the medical record. She said she did not have a good answer about the cognition, and it might have been related to the pain medication and the dementia was a click error.

A phone interview was conducted on 02/14/22 at 12:32 PM with Resident #328's family member. She said the facility was trying to dispute her cognition when she was there the first day and also in the medical record. She noted the Resident was fine and both the nurses and physicians at the hospital had commented how good the resident's mind was. She noted the resident remembered everything. The family member noted she was with the resident from morning until visiting was over and the resident's cognition had not declined in the facility.

MDS Nurse #1 was interviewed on 01/28/22 at 11:57 AM about Resident #328's care plan. MDS

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nurse #1 noted on 7/26 that the cognitive issues had been added on 07/26/21, she reviewed the record and noted the NP note and was unable to validate the reason for the change.

A phone interview was done with the interim Director of Nursing on 02/01/22 at 2:10 PM regarding medical record documentation. She was asked about the care plan and documentation of cognitive issues with a resident who was alert and oriented and had a Brief Interview for Mental Status assessment of 15 (cognitively intact). She stated she expected the care plan to be accurate to reflect the residents.