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	345519	A. BUILDING _____ B. WING _____	C 02/25/2022

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/21/22 through 02/25/22. The facility was found not in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OPKR11.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an	E 004		3/30/22

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

Electronically Signed | 03/21/2022

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E 004	Continued From page 1 all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: The facility's EP Plan was reviewed which was signed by a previous Administrator and dated 9/4/19. There was no other documentation provided to indicate the plan had been reviewed since 9/4/19. An interview with the Administrator on 2/25/22 at 10:01 AM revealed he did not know why the EP plan had not been updated.	E 004	E004 The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficient practice. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. On 03/18/2022, the Administrator was educated regarding the requirement for the annual review and update of the EOP by the IDT by the Regional Director of Operations (RDO). Administrator updated the Emergency Operations Plan (EOP) with current key	

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E 004	Continued From page 2	E 004	personnel, employee phone list and current vendors on 03/01/2022. The EOP was reviewed during the AM QA Stand-Up meeting on 03/02/2022 with the Inter-Disciplinary Team (IDT). The IDT was educated regarding facility requirement to review and update the EOP at least annually by the RDO on 03/18/2022. Administrator will monitor for any new changes established by rule or regulation and discuss with the IDT as needed. The facility will incorporate necessary changes in the EOP after review by the IDT. The RDO will monitor annually to ensure sustained compliance. Date of Compliance: 03/30/2022	
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 02/21/22 through 02/25/22. Event ID# OPKR11 Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J CFR 483.12 at tag F607 at a scope and severity J The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/24/21 and was removed on 02/25/22. An extended survey was conducted. Thirty one of the 66 complaint allegations were	F 000		

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F 000	Continued From page 3 substantiated resulting in deficiencies. After CMS review the 2567 was amended on 3/25/22. The following changes were made: Tag E004 scope and severity changed to "F" Tag F623 scope and severity changed to "D" Tags F637, F640, and F641 example 2 deleted	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		3/30/22

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F 550	Continued From page 4 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observations, the facility failed to provide a dignified dining experience by standing while assisting a resident with eating for 1 of 5 residents reviewed for dignity (Resident #23). Findings included: Resident #23 was admitted to the facility on 8/1/21 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 11/19/21 revealed Resident #23 had severe cognitive impairment. He required limited assistance with eating with 1-person physical assistance. Resident #32 was care planned for potential nutritional problem related to therapeutic diet and activity of daily living self-care performance related to dementia. On 2/21/22 at 12:16 PM Resident #23 was observed sitting at a table in the dining area on the 300 hall. Nursing Assistant #2 was observed standing next to Resident #23 assisting him with	F 550	F550 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. For clinical services, a corrective action was obtained on 03/03/2022. Based on observation a dignified dining experience was not maintained for 1 of 5 residents. For Resident #23 assistance at meals was not provided per orders or in a dignified manner. Resident #23 was assessed by PT and ST; total assistance with meals ordered and diet texture was modified to Pureed. MAR, PCC, and Care plans updated to reflect assistance orders for resident #23 for nursing assistants to	

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F 550	Continued From page 5 eating his meal. An interview was conducted with NA #2 on 2/21/22 at 12:17 PM and she stated she sat down to assist residents with eating but Resident #23 could feed himself. She stated he just needed to know the food was there. On 2/21/22 at 12:18 PM Resident #23 was observed trying to place a piece of bread in his mouth but was unable to get the bread up to his mouth. Resident #23 stopped trying to eat his meal. On 2/21/22 at 12:20 PM NA #2 was observed seated next to Resident #23 assisting him with his meal. On 2/25/22 at 10:30 AM the Administrator stated feeding assistance should be provided while seated next to the resident.	F 550	review prior to meals. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/16/2022 in-service was completed with NA#2 with focus on remaining seated while providing feeding assistance. On 03/18/2022, all nursing and nursing assistant staff were in-serviced including ADL's Eating Presentation, Tray Delivery and Set-Up for Nursing/CNA Training and Nursing and Nursing Assistant Meal Procedures. On 3/18/2022 all resident orders were reviewed to create a comprehensive list of residents that require assistance at meals and MAR and PCC were updated. Meal tickets were also altered to highlight meal assistant requirements. By 3/30/2022 all staff in which may feed a resident as a part of their job duties will have completed the Feeding Program and will be classified as competent to provide assistance at meals. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " ADL□s Eating Presentation " Tray Delivery and Set-up for Nursing/CNA Training " Nursing and Nursing Assistant Meal Procedures This information has been integrated into the standard orientation training and in the required in-service refresher courses for	

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F 550	Continued From page 6	F 550	all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Facility Administrator and/or Designee will monitor meal service 5 times weekly x 4 weeks, then weekly x 2 months, and then monthly x 3 months using the Quality Assurance Audit tool. Monitoring will include ensuring staff are using the proper channels to review which residents require assistance at meals, providing assistance with meals, and updating multiple channels to provide accurate information regarding assistance at meals. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 03/30/2022	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		3/30/22

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F 580	Continued From page 7	F 580		

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)
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

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F 580	Continued From page 8 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, resident, staff, and physician interviews the facility failed to notify the physician a medication was not administered to a resident and did not notify the physician of the presence of an infection for 2 of 4 residents reviewed for notification of change. (Resident #46 and Resident #9) Findings included: 1. Resident #46 was admitted to the facility on 3/4/19. Her active diagnoses included other psychotic disorder not due to a substance or known physiological condition, and major depressive disorder with psychotic symptoms. Resident #46 was ordered on 10/23/19 to have Seroquel 250 milligrams by mouth at bedtime for psychosis. Resident #46's Medication Administration Record (MAR) for September 2021 revealed on 9/24/21 Nurse #11 documented Seroquel 250 milligrams by mouth was not given and to see nursing notes. On 9/25/21 and 9/26/21 Nurse #12 documented Seroquel 250 milligrams by mouth was not given and to see nursing notes. A review of Resident #46's medical records for 09/24/21, 09/25/21 and 09/26/21 revealed there were no nursing notes in reference to Seroquel not being administered. There was no documentation of notifying the physician of the medication not being given.	F 580	F580 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: On 09/27/21, the McNeill□s Pharmacy delivered residents medication to the facility. Medical Director was notified of missed dosages of Seroquel for Resident #46 on 3/14/2022 by Quality Assurance Nurse Consultant (QANC). No new orders received. On 10/10/21, Nurse #13 notified Resident□s # Physician after speaking to Nurse #2. New orders received. However, resident was sent to hospital for further treatment on 10/11/2021. On 2/23/2022 the Physician was interviewed and stated he does not feel the delay in starting the antibiotic nor the type of antibiotic started would have prevented	

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F 580	Continued From page 9 Nurse #11 and Nurse #12 were unavailable for interview. During an interview on 2/21/22 at 11:09 AM Resident #46 stated at some point in September of 2021 she did not receive her Seroquel as ordered and did not understand why. During an interview on 2/22/22 at 11:11 AM the Administrator stated he was unaware of any concerns with Resident #46 ' s Seroquel in September 2021. He concluded when medications were not administered, the physician was to be notified and he had no documentation this notification was done. During an interview on 2/23/22 at 8:16 AM Physician #1 stated he could not remember if he was notified in September 2021 of Resident #46 not receiving her Seroquel. He concluded there were no negative outcomes from Resident #46 not receiving Seroquel those three days. During an interview on 2/23/22 at 10:32 AM the Corporate Nurse Consultant stated they did not have any further documentation of what happened with Resident #46's Seroquel on 9/24/21 through 9/26/21. She concluded the nurses should have notified the physician of the medication not being provided and there was no documentation that such notification had occurred. 2. Resident #9 was admitted to the facility on 04/26/2021 with diagnoses including diabetes and dementia. A review of the weekly skin assessment for Resident #9 dated 10/07/2021 revealed he had	F 580	resident from being hospitalized for a Methicillin-Resistant Staphylococcus Aureus (MRSA) skin infection. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents in the facility who have physician orders have the potential to be affected. Beginning 3/15/2022, the Quality Assurance Nurse Consultant audited 100% of all residents MARs and TARs for notifications of medications not available to the residents. This was completed on 3/17/2022. On 3/17/2022, the Director of Nurses (DON) or designee initiated daily audits of all medications not available and review to ensure all notifications were or were not completed in a timely manner. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 03/02/2022, the Quality Assurance Nursing Consultant and designee began reeducating all full time, part time, agency staff, and PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics (See education): " Medication Availability from Back up Pharmacy " Notification to Physician of Change in Condition " Following Physician Orders This information has been integrated into the standard orientation training and will	

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F 580	Continued From page 10 no new areas of skin impairment. On 02/22/2022 at 7:16 PM a telephone interview with Nurse #15 indicated she performed Resident #9's weekly full body skin assessment on 10/07/2021. She stated Resident #9 had no areas of redness or other concerns observed during that assessment. A review of an incident report for Resident #9 dated 10/09/2021 at 4:39 PM completed by Nurse #2 revealed the nurse aide (NA) reported Resident #9 had a stage 1 (reddened) area to Resident #9's right buttock and an area on Resident #9's left posterior (rear) shoulder that appeared red, warm and was painful to touch. It further indicated Resident #9's family member, physician, and the facility treatment nurse were notified. On 02/22/2022 at 3:56 PM an interview with Nurse #2 indicated she was caring for Resident #9 on 10/09/2021 on the 3PM-11PM shift. She stated the NA reported to her that Resident #9 had some abnormal skin areas. She went on to say when she assessed Resident #9, she observed a reddened area to his right buttock, and a large area on his left shoulder that was red, swollen, warm to the touch and painful to Resident #9. Nurse #2 stated the area on Resident #9's left shoulder appeared infected and had two white pustules (bulging patch of skin). She stated the areas were not open. She further indicated she completed and submitted an incident report which she thought automatically notified Resident #9's physician and the treatment nurse. Nurse #2 stated she did not call Resident #9's physician to notify him on 10/09/2021 and did not recall notifying the treatment nurse by telephone.	F 580	be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 03/30/2022, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F580 Notification of Change & Medication Availability Report Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor notification process for new recommended orders from consults, outside provider appointments, or emergency room visits. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/30/2022	

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F 580	Continued From page 11	F 580		

A review of a physician's order dated 10/10/2021 at 9:32 PM revealed Keflex (an antibiotic) 500 milligrams by mouth twice daily for 7 days.

A review of the October 2021 Medication Administration Record (MAR) for Resident #9 revealed he received his first dose of Keflex on 10/10/2021 at 9:00 PM. It further revealed Resident #9's body temperature was documented as the following: 10/9/2021 7AM-3PM shift-98.6 degrees Fahrenheit (F), 3PM-11PM shift- 98.6 degrees F, 11PM-7AM shift-97.1 degrees F, 10/10/2021 7AM-3PM shift-98.7 degrees F, 3PM-11PM shift 98.1degrees F, 11PM-7AM shift-98.1 degrees F (the average body temperature of adults is 97 degrees F to 99 degrees F).

On 02/22/2022 at 4:21 PM an interview with Unit Manager (UM) #1 indicated the completion of the incident report by Nurse #2 would not notify Resident #9's physician. He went on to say both he and the treatment nurse had access to the facility incident reports off site and would at times check these, however this did not provide automatic or immediate notification. He stated because Resident #9 had a change in condition on 10/09/2021 with signs and symptoms of infection, Nurse #2 should have notified Resident #9's physician by telephone immediately on 10/09/2021.

On 02/23/2022 at 8:56 AM an interview with the Nurse #13 indicated she was the facility's treatment nurse. She stated Nurse #2 notified her on 10/10/2022 of Resident #9's skin concerns by telephone. Nurse #13 stated she called Resident #9's physician on 10/10/2021 after speaking with

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F 580	Continued From page 12 Nurse #2 and received the physician's order for Keflex. On 02/23/2022 at 10:12 AM an interview with the Administrator indicated Nurse #2 should have notified Resident #9's physician immediately on 10/09/2021 when Resident #9 was first observed to have signs and symptoms of infection. On 02/23/2022 at 1:20 PM a telephone interview with Physician #2 indicated he was notified of Resident #9's left shoulder area on 10/10/2021. He stated it sounded to him like Resident #9's left shoulder area was inflamed with a possible skin infection so he ordered an antibiotic to treat the infection. He stated he would have expected to be notified immediately when Nurse #2 discovered the area. He went on to say the sooner antibiotic treatment was initiated when there was infection the better the outcome would be. Physician #2 further indicated unfortunately, in this case, the infectious organism turned out to be Methicillin-resistant Staphylococcus aureus (MRSA) which was resistant to Keflex. He stated beginning antibiotic treatment on 10/09/2021 instead of 10/10/2021 would not have changed Resident #9's outcome or prevented his hospitalization.	F 580		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582		3/30/22

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for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's

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F 582	Continued From page 14 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the Centers for Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) for 2 of 3 residents reviewed for beneficiary notification review (Resident #15 and Resident #590). Findings Included: 1. Resident #15 was admitted to the facility on 2/15/21 with diagnoses including cerebral infarction. She was admitted to Medicare Part A skilled services on 10/12/21. Resident #15 ' s Medicare Part A skilled services ended on 12/12/21. She remained in the facility. A review of the medical record revealed Resident #15 was not issued a CMS Notice of Medicare Non-Coverage (NOMNC) letter which explained the Medicare Part A coverage for skilled services would end on 12/12/21. 2. Resident #590 was admitted to the facility on 9/3/21 and discharged on 9/28/21. Her diagnoses included left femur neck fracture. She was admitted to Medicare Part A skilled services on 9/3/21. Resident #590 ' s Medicare Part A skilled services	F 582	F582 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance so that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. All residents have the potential to be affected by this alleged deficient practice. On 03/15/2022, the facility administrator audited all current residents with pending discharge dates. This was completed on 03/16/2022. On 03/16/2022, the facility Administrator in-serviced the IDT team for Medicare and discharges (Business Office Manager, Admissions, Medical Records, Therapy and MDS Nurses). This in-service included the following topic: Ensure ABN Forms are provided within 48 hours advanced notice to resident and/or RP and maintain a copy as supportive documentation. Social Worker currently on medical leave but will be in-serviced	

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F 582	Continued From page 15 ended on 9/27/21. A review of the medical record revealed Resident #590 was not issued a CMS Notice of Medicare Non-Coverage (NOMNC) letter which explained the Medicare Part A coverage for skilled services would end on 9/27/21. An interview was conducted with the Administrator on 2/25/22 at 1:00 PM. He stated the Social Worker was out and he was completing the NOMNC forms in her absence. He stated he was unable to locate the NOMNC forms for Resident #15 and Resident #590.	F 582	upon return to work. The Director of Nursing will ensure that any IDT team member who has not received this training by 03/16/2022 will not be allowed to return to work until the training is completed. This information has been integrated into the standard orientation training for all IDT members and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The Director of Nursing and facility Administrator will monitor this issue using the Survey Quality Assurance Tool for Monitoring. The monitoring will include reviewing the ABN Binder normally kept on file in the SW office. This will be completed weekly for 4 weeks, then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life □ QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager, Activities Director and Social Worker. Date of Compliance: 03/30/2022	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		3/30/22

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F 584	Continued From page 16 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584		

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F 584	Continued From page 17 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain a clean, homelike environment for 8 of 8 resident rooms (Rooms 204, 406, 708, 805, 202, 203, 206 & 803) observed for environment. Findings included: 1a. An observation of Room #406 on 2/21/22 1:41 PM revealed a black substance on the floor along the wall by the closet behind the room door. Further observation revealed a black substance on the floor around the toilet in the bathroom. Additional observations of Room #406 conducted on 2/22/22 at 4:20 PM, 2/23/22 at 8:44 AM and 1:20 PM revealed the conditions remained unchanged. An observation of Room #406 and interview with the Maintenance Director on 2/23/22 at 1:20 PM revealed he was also the Housekeeping Director. He stated he was aware of the black substance on the floor. He further stated it was due to a wax buildup and he was working with a contract company to determine the correct chemical to use on the floor. The Maintenance Director also stated he had tried a floor chemical, but it hadn't worked. He also stated he was looking into different equipment and working with the floor cleaning technicians to figure out a technique to get rid of the black substances on the floor. The Maintenance Director stated he did not have any documentation related to the contract company and the different chemicals or equipment. b. An observation of Room #204 on 2/21/22 at	F 584	F584 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance so that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 03/07/2022 a comprehensive audit of all resident rooms and common areas of the physical plant was initiated by the IDT under the direction of the Facility Administrator. This process was completed on 03/10/2022. Systemic Changes On 03/10/2022, the RDO and Facility Administrator began in-servicing all environmental services staff regarding proper steps to deep clean resident rooms and general cleaning techniques for all common areas. The Maintenance Director will ensure that any environmental services (Housekeeping or Maintenance) who has	

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F 584	Continued From page 18 11:30 AM revealed 5 nickel to quarter size areas of dried food on the right side of the bed by the bathroom. Additional observations of Room #204 conducted on 2/22/22 at 12:00 PM, 3:35 PM and 4:55 PM and 2/23/22 at 12:54 PM and 1:10 PM revealed the conditions remained unchanged. An observation conducted on 2/24/22 at 8:30 AM revealed the floor had been cleaned. An observation of Room #204 and interview with the Maintenance Director on 2/23/22 at 1:10 PM revealed he was also the Housekeeping Director. He stated he was surprised to know that the dried food had been on the floor for 3 days. He stated that the resident room floors get moped every day. He also stated housekeeping was short staffed. c. An observation of Room #708 on 2/24/22 at 8:40 PM between the bed and the door there was a nickel size dark brown area with a 4" long smear. Another observation included 3 large areas of a pink streaked substance on the side of the bed toward the door. The bathroom in Room #708 revealed a 1" wide black/brown area around the base of the toilet with a 3" x 3" brown area on the wall side of the toilet and a torn and dirty shower curtain. Additional observations refrigerator in the room revealed 2 yellow/orange marble size hard objects in the back of the bottom drawer. An observation of Room #708 and interview with the Maintenance Director on 2/24/22 at 9:04 AM confirmed that the room had a black/brown area between the bed and the door. He stated the large pink areas were spilled nail polish and he had tried to get them up but was unable to due to him being prohibited to bring nail polish remover	F 584	not received this training by 03/21/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all environmental services staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Facility Administrator will monitor this issue using the Survey Quality Assurance Tool for Monitoring. The monitoring will include reviewing resident rooms and physical plant. This will be completed weekly for 4 weeks and then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life-QA committee and corrective action initiated as appropriate. They Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Managers, Staff Development Coordinator, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager, Social Worker and Admissions/Marketing Team. Date of Compliance: 03/30/2022	

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into the building. He confirmed the black/brown areas around the toilet base were present. He stated the torn and dirty shower curtain should have been replaced but he did not have any available. He stated the yellow/orange objects in the refrigerator were dried food. He stated the room was not as well cleaned as it could have been and stated it was due to lack of staffing.

An interview on 2/23/22 at 12:57 PM with Housekeeper #1 revealed she cleaned her assigned rooms daily. She stated she typically has 22 rooms as well as common areas such as nurses' stations, dining rooms, sitting areas, and soiled linen closets. She stated sometimes she was assigned to the 700 and 800 hall and sometimes she was unable to complete her assignment and had to leave things to be done the next day.

An interview on 2/23/22 at 1:29 PM with Housekeeper #3 revealed he was assigned as a floor technician and it was his job to strip and wax the floors. He stated sometimes he was assigned to help out with cleaning the rooms. He stated he decided which floors to clean by looking at them and he does not have a set schedule of floors to clean. He also stated he does not go into a resident's room unless he has a specific reason or was assigned to clean the room. He also stated sometimes he sees a resident's room is empty and he takes it on himself to strip and wax that room. He stated he had not been given information about cleaning the black areas along the walls and toilets.

An interview on 2/24/22 at 10:30 AM with the Administrator revealed he was aware of the cleaning concerns and expected the resident

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rooms to be cleaned better.

d. An observation of Room #805 on 2/24/22 at 8:48 AM revealed the television cable box and wiring were hanging down behind the television about 8" and 14". Further observation of the bathroom revealed a black patchy area approximately 3" wide around the base of the toilet, a green patchy area on the shower seat approximately 10" x 12", and the shower curtain was grey/black at the bottom.

An observation of Room #805 and interview with the Maintenance Director on 2/24/22 at 9:10 AM revealed the television cable box and wiring sometimes hung down behind the television and were within reach of a resident. He stated they tried to put them behind the television but sometimes they fell. He confirmed the area around the toilet base was dirty and the shower curtain was dirty and needed to be changed. He stated the areas in the shower and shower seat were discolored due to the age of the shower and seat and he did not know how to get them clean.
e. On 02/21/22 at 12:37 PM an observation of room 202-B revealed a 3 inch wide by 1 foot long hole in the wall behind the bed exposing the space in the wall between rooms.

f. On 02/21/22 at 3:33 PM an observation of room 203 revealed a hole in the wall behind the door. The hole is the shape of the door handle. During the observation Resident #34 stated the hole had been there as long as she could remember.

g. On 02/21/22 12:42 PM an observation of room 206 A revealed a hole in the wall behind the bed exposing the plaster and sheet rock.

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h. On 02/21/22 11:38 AM an observation of room 803 revealed a 2 foot by 2 foot square of unpainted plaster behind the recliner.

On 2/24/22 at 10:07 AM an interview with the Maintenance Director revealed the maintenance logbooks for each nursing station were monitored by the maintenance staff member and repairs may be done immediately if it is something that needs immediate attention. The Maintenance Director stated the maintenance staff member would request help if it was needed. He stated he had a list of maintenance items which needed to be completed. He said he had identified these things by monitoring rooms. He added the facility was having difficulty matching paint using the current local hardware store and planned to reach out to a paint supply store based on a conversation he had with the maintenance staff member. The Maintenance Director stated they were going to use a fiberglass type of material behind the beds. During the interview he demonstrated the fiberglass type of material was a 3 foot by 5 foot piece of hard material which was screwed onto the wall behind the bed.

A review of the list of maintenance items revealed one page of a 3 page handwritten note titled Bathrooms. The note indicated room 202 was listed as "patching/touchup" and room 203 was listed as and patching/touchup & caulking." None of the other rooms were on this list.

During an interview with the Administrator on 2/25/22 at 10:15 AM he stated the facility was trying to make the correct repairs, but it was an ongoing project. He said since this is the residents ' home it should be in better repair.

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F 600	Continued From page 22	F 600		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview, the facility failed to protect 1 of 1 resident (Resident #65) from employee to resident physical abuse. On 12-24-21 while providing care to Resident #65 Nursing Assistant (NA) #1 grabbed onto his right arm, jerked his arm and slapped his face resulting in the bridge of Resident #65's nose bleeding and bruising to his right upper and lower arm. Immediate Jeopardy began on 12-24-21 when the facility failed to protect Resident #65 from employee to resident physical abuse. Immediate Jeopardy was removed on 2-25-22 when the facility implemented an acceptable credible allegation on Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not	F 600	F600 Corrective Action for Affected Residents Resident #65 was assessed immediately after the event on 12/24/2021 by the staff nurse. The nurse noted that the resident had a fresh reddish purple bruise on his right forearm down to his wrist, top of right thumb. Also has a fresh abrasion/scab with no bleeding on bridge of nose. No other injuries noted The Physician and resident responsible party were notified on 12/24/2021 by staff nurse. No new orders were received. The involved agency staff member was suspended and the agency was notified that the staff member would not be allowed to return. An investigation was initiated. Corrective action for residents with the	2/25/22

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F 600	Continued From page 23 Immediate Jeopardy to ensure education is completed and monitoring systems put in place are effective. Findings included: Resident #65 was admitted to the facility on 9-22-21. The quarterly Minimum Data Set (MDS) dated 12-16-21 revealed Resident #65 was cognitively intact. Resident #65 was not coded for any behaviors or refusal of care and had not received any anticoagulant (blood thinner) medications during the look back period. Resident #65's care plan was reviewed and revealed no care plans related to behaviors or refusals of care. A nursing note completed by Nurse #1 dated 12-24-21 at 5:35am documented Resident #65 was combative with NA #1 during incontinence care and when the NA attempted to reposition the resident in bed, Resident #65 hit himself in the face. A nursing note completed by Nurse #1 dated 12-24-21 at 6:20am documented an assessment of Resident #65's face showing a scratch to the bridge of Resident #65's nose. Another note completed by Nurse #1 on 12-24-21 at 7:10am revealed an assessment of Resident #65 was completed showing bruising to the resident's right upper arm and right forearm with Resident #65 informing Nurse #1 that NA #1 grabbed him and "yanked" him.	F 600	potential to be affected by the alleged deficient practice. All residents have the potential to be affected by this deficient practice. On 02/23/2022, current residents that were able to be interviewed, were asked if they had been abused or mistreated by staff. This was completed by the activity director and the health information director. No new allegations of abuse were identified. Also, on 02/23/2022, skin assessments were completed on current residents that were not interviewed. This was completed by the staff nurses. These residents were assessed to identify if there were any sign of abuse such as bruises or scratches of unknown origin. No additional residents were identified. Systemic Changes Training began on 02/23/2022. This training will include all current staff including agency. This training included how to manage behaviorally difficult residents. Training was completed by the Nurse Clinical Consultant and Staff RN. Areas discussed include: attempting to identify the cause of the resident behavior and eliminate it if possible, respect the resident□s need for personal space, taking threats seriously and keeping distance, remaining calm, speaking in soft, low, calm voice, not making the resident feel trapped or cornered, not turning your back on the resident, avoid touching the resident, show interest in what they are saying, empathize with the resident, reassure the resident, praise self-control, do not argue with the resident	

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F 600	Continued From page 24 Resident #65 was interviewed on 2-21-22 at 2:15pm. The resident stated on Christmas Eve (12-24-21) a NA came into his room, held his arms down and hit him on his forehead leaving a bruise and broke his skin on his thumb with her fingernail. He explained he had informed the Administrator, nurse and that the police were notified. Resident #65 stated he was concerned that the NA still worked at the facility. During a telephone interview with NA #1 on 2-23-22 at 3:58pm. NA #1 explained she was unfamiliar with Resident #65 because it was her first day (12-24-21) working at the facility and when she had entered Resident #65's room around 5:30am on 12-24-21, the resident had requested to be repositioned in the bed. She reported when she grabbed Resident #65's draw sheet, the resident swung at her, so she grabbed his arm, but the resident continued to try and hit her. NA #1 stated she then left the room and reported the incident to Nurse #1. She said she had not hit Resident #65. She explained she had education on abuse over the years and would not hurt a resident. NA #1 stated Resident #65 had hurt himself to get her into trouble. The NA said she had not encountered an aggressive resident before but now thought she should have just left the room instead of grabbing his arm. She also explained she had not been back to the facility since 12-24-21. Nurse #1 was interviewed by telephone on 2-23-22 at 4:45pm. Nurse #1 confirmed she was the nurse on duty caring for Resident #65 on 12-24-21 from 11:00pm to 7:00am. She stated she entered Resident #65's room for medication pass around 5:45am and found Resident #65 upset and crying. Nurse #1 reported Resident	F 600	and make sure that your body language is not threatening. The Director of Nursing and Nurse Clinical Consultant as well as Facility Administrator will ensure that any staff who does not complete the in-service training by 2/24/2022 will not be allowed to work until the training is completed. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will monitor the issue using the Survey Quality Assurance Tool Abuse. The monitoring will include reviewing 5 non- interview able residents to see if they have any signs or symptoms of abuse such as bruises, scratches or injuries of unknown origin and 5 interview able residents to see if they had concerns related to abuse. This will be done weekly for 4 weeks and then monthly times 2 months or until resolved by the Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life-QA Committee and corrective actions initiated as appropriate. The Quality of Life Committee consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinators, Unit Support Nurse, MDS coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Completion = 02/25/2022	

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#65 informed her NA #1 had held his arms down and hit him in his face. She stated she assessed Resident #65 briefly and saw his right arm was red and then went and discussed the allegation with NA #1. The nurse said NA #1 told her Resident #65 had hit her and she held his arms down but had not hit him in his face. NA #1 informed her that the resident hit himself in his face while she (NA #1) was trying to reposition him in the bed. She stated she informed the Director of Nursing and the Nursing Supervisor of the allegation of employee abuse and instructed NA #1 to not enter Resident #65's room for the rest of the shift. Nurse #1 stated she continued her medication pass entering another resident room and the resident had informed her NA #1 had been rough with her while providing incontinence care. The nurse stated she did not ask the resident any questions or examine the resident. She further stated, "I just did not think about it. I was concerned with Resident #65." She also said she could not remember who the other resident was. Nurse #1 spoke about Resident #65 and explained that he sometimes had agitation expressed through verbal behaviors, but he had never been combative or stated anything to indicate that a staff member had physically abused him before.

A nursing note by Nurse #2 dated 12-24-21 at 10:15am documented she saw bruises on Resident #65's right forearm and a small laceration on his nose with dried blood. The nurse documented that Resident #65 told her he was "beat up" and that he had his arms held down and hit in the nose. Nurse #2's note indicated she had worked the day before (12-23-21) and Resident #65 did not have any bruises or laceration to his nose.

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Nurse #2 was interviewed by telephone on 2-23-22 at 1:55pm. Nurse #2 confirmed she worked 7:00am to 3:00pm on 12-24-21 and was assigned to care for Resident #65. She explained Nurse #1 had informed her of the incident with Resident #65 and NA #1 that occurred during the 11:00pm to 7:00am shift. Nurse #2 stated when she saw Resident #65 around 8:00am on 12-24-21, the resident told her he had been beat up with his arms held down and hit in the nose. She observed bruising to his right arm and a laceration to his nose that had dried blood. Nurse #2 also explained when she worked on 12-23-21 during the 7:00am to 3:00pm shift, Resident #65 did not have any bruising on his arms or laceration to his nose. Nurse #2 stated Resident #65 had always been pleasant with her and had never been combative. She also said Resident #65 had not made allegations of physical abuse before and that she trusted that what he told her was the truth.

Review of the initial allegation report completed by the former Director of Nursing (DON) dated 12-24-21 revealed the following: Resident #65 reported NA #1 came into his room at approximately at 5:30am on 12-24-21 and "snatched the covers off of me". He stated the NA told him "I have been a NA for 30 years and I am going to show you to pull [yourself] up." The resident stated in the report the next thing he knew the NA was grabbing onto his right arm and jerking him. He reported he began shaking his arm trying to get the NA to let him go and the next thing he knew NA #1 slapped him in the face causing the bridge of his nose to bleed. The report indicated on assessment of Resident #65 he had fresh reddish-purple bruising on his entire

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right forearm down to the top of his wrist and a bruise to the base of his right thumb. Resident #65 also had a fresh abrasion to the bridge of his nose that was no longer bleeding. Report documentation revealed the police were notified on 12-24-21 at 2:10pm.

Review of the police report dated 12-24-21 at 4:00pm revealed documentation of minor injuries to Resident #65 to include bruising to his right arm and a cut to the bridge of his nose.

The Administrator was interviewed on 2-25-22 at 11:30am. The Administrator stated Resident #65 never displayed any type of aggressive behaviors towards the staff or refused care prior to the incident on 12-24-21. He also stated Resident #65 had not made previous allegations of physical abuse. He revealed that due to the resident's injuries and recollection of the events the allegation was substantiated.

The Administrator was notified of immediate Jeopardy on 2-23-22 at 1:38pm.

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 12/24/2021, Resident #65 reported to his nurse that his assigned nursing assistant had hit him. At approximately 5:30am on 12-24-21 a Nursing Assistant (NA #1) came into Resident #65's room and "snatched the covers off" and when the resident asked the NA not to snatch his covers off the NA told him that she was going to show him how to reposition himself and grabbed his right arm. Resident #65 stated that he tried to get loose from the NA's grasp and that was when

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the NA slapped Resident #65 on his face causing the bridge of his nose to bleed. The Director of Nursing was notified by the staff nurse on 12/24/2021.

Resident #65 was assessed immediately on 12/24/2021 by the staff nurse. The nurse noted that the resident had a "fresh reddish-purple bruise on his right forearm down to his wrist, top of right thumb. Also has a fresh abrasion/scab with no bleeding on bridge of nose. No other injuries noted" The Physician and resident responsible party were notified on 12/24/2021 by staff nurse. No new orders were received. The involved agency staff member was suspended, and the agency was notified that the staff member would not be allowed to return. On 12/24/2021 the police were notified, and they obtained a statement from the resident. A 24-hour report was also submitted on 12/24/2021 by the facility and an investigation report was submitted on 12/29/2021. The facilities investigation concluded that it is likely that the resident was hit by the nursing assistant. After interviews and chart reviews the Director of Nursing identified that the root cause was that the aide did not follow policies and did not ensure resident safety by exiting the room to de-escalate the situation related to an agitated or aggressive resident.

All residents have the potential to be affected by this deficient practice.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

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On 02/23/2022, current residents that were able to be interviewed, were asked if they had been abused or mistreated by staff. This was completed by the activity director and the health information director. No new allegations of abuse were identified. Also, on 02/23/2022, skin assessments were completed on current residents that were not interviewed. This was completed by the staff nurses. These residents were assessed to identify if there were any sign of abuse such as bruises or scratches of unknown origin. No additional residents were identified.

On 12/24/2021, the staff development coordinator in-serviced all nursing staff on the abuse and prohibition policy. This training was completed for all staff and has been ongoing since 12/24/2021 for new hires.

Additional training began on 02/23/2022. This training will include all current staff including agency. This training included how to manage behaviorally difficult residents. Training was completed by the Nurse Clinical Consultant and Staff RN. Areas discussed include: attempting to identify the cause of the resident behavior and eliminate it if possible, respect the resident's need for personal space, taking threats seriously and keeping distance, remaining calm, speaking in soft, low, calm voice, not making the resident feel trapped or cornered, not turning your back on the resident, avoid touching the resident, show interest in what they are saying, empathize with the resident, reassure the resident, praise self-control, do not argue with the resident and make sure that your body language is not threatening.

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F 600	Continued From page 30 The Director of Nursing and Nurse Clinical Consultant as well as Facility Administrator will ensure that any staff who does not complete the in-service training by 2/24/2022 will not be allowed to work until the training is completed. Alleged IJ Removal Date: 2/25/22 The facility's credible allegation of Immediate Jeopardy was validated on 2-25-22 with interviews with facility staff including nursing staff, dietary and housekeeping. The staff verbalized receipt of education on types of abuse, reporting abuse and how to interact with behaviorally challenged residents. A sample of residents were interviewed and stated they were questioned about abuse and educated on reporting abuse. Staff education documentation, audits and monitoring were reviewed. The facility's date of Immediate Jeopardy removal of 2-25-22 was validated.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		2/25/22

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F 607	Continued From page 31 Based on record review, staff and Physician interview, the facility failed to follow their abuse policy to implement interventions to protect residents from physical abuse. On 12-24-21 at approximately 5:30am Nursing Assistant (NA) #1 grabbed Resident #65's right arm, jerked his arm and slapped his face resulting in the bridge of Resident #65's nose bleeding and bruising to his right upper and lower arm. NA #1 was allowed to complete her shift and continue to provide care to other residents following the incident. The facility also failed to implement their abuse policy in the areas of reporting and investigating abuse. This was for 1 of 1 resident (Resident #65) reviewed for abuse. Immediate Jeopardy began on 12-24-21 when NA #1 physically abused Resident #65 and the facility failed to implement interventions to protect other facility residents from NA #1. Immediate Jeopardy was removed on 2-25-22 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not Immediate Jeopardy to ensure education is completed and monitoring systems put in place are effective. Example 1b was cited at scope and severity level of "D". Findings included: Review of the facility's "Abuse Prohibition" policy and procedure dated January 2021 revealed in part, the individual conducting the investigation will interview/review resident abuse report, interview person reporting the incident, resident, witnesses, resident's physician, roommate, other	F 607	F607 Corrective Action for Affected Residents Resident #65 was assessed immediately after the event on 12/24/2021 by the staff nurse. The nurse noted that the resident had a fresh reddish purple bruise on his right forearm down to his wrist, top of right thumb. Also has a fresh abrasion/scab with no bleeding on bridge of nose. No other injuries noted The Physician and resident responsible party were notified on 12/24/2021 by staff nurse. No new orders were received. The involved agency staff member was suspended and the agency was notified that the staff member would not be allowed to return. An investigation was initiated. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by this deficient practice. On 02/23/2022, current residents that were able to be interviewed, were asked if they had been abused or mistreated by staff. This was completed by the activity director and the health information director. No new allegations of abuse were identified. Also, on 02/23/2022, skin assessments were completed on current residents that were not interviewed. This was completed by the staff nurses. These residents were assessed to identify if there were any sign of abuse such as bruises or scratches of unknown origin. No additional residents were identified. Systemic Changes Additional training began on 02/24/2022	

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F 607	Continued From page 32 residents the employee had contact with, staff members and review events leading up to the incident. All potentials for harm must be removed during the investigation, this may constitute suspending an employee of suspected activity. The report must be submitted to the state agency immediately but not later than 2 hours following the allegation of abuse. 1. Resident #65 was admitted to the facility on 9-22-21. Review of the census report for hall 200 on 12-24-21 revealed 20 residents resided on the hall. A nursing note completed by Nurse #1 dated 12-24-21 at 5:35am documented Resident #65 was combative with NA #1 during incontinence care and when the NA attempted to reposition the resident in bed, Resident #65 hit himself in the face. Nurse #1 documented on 12-24-21 at 5:58am that the facility's Director of Nursing was notified of the allegation of employee to resident physical abuse. A nursing note completed by Nurse #1 dated 12-24-21 at 6:20am documented an assessment of Resident #65's face showing a scratch to the bridge of Resident #65's nose. Another note completed by Nurse #1 on 12-24-21 at 7:10am revealed an assessment of Resident #65 was completed showing bruising to the resident's right upper arm and right forearm with Resident #65 informing Nurse #1 that NA #1 grabbed him and "yanked" him.	F 607	by the Nurse Consultant and Nurse Administration Team. This training will include all contracted, full time, part time ,prn _ all staff. This training included: When abuse is suspected or reported, staff must immediately report the suspicion or allegation to the nurse, Administrator, or Director of Nursing. Facility investigation beginning steps (Take whatever steps are necessary to protect the residents and to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. This includes immediate suspension of the accused employee or employees.)It is imperative that all staff understand that when an allegation of staff to resident abuse is made that the accused staff member must immediately be removed from the floor with no resident contact until the investigation is completed to protect the facility residents. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Regional Director of Operation or the Quality Assurance Nurse Consultant will monitor the issue using the Survey Quality Assurance Tool Abuse. The monitoring will include reviewing all abuse allegations to ensure that policies were followed including that the accused employee was sent home immediately and not allowed to work until the investigation was completed. This will be done weekly for 4	

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F 607	Continued From page 33 Review of the initial allegation report completed by the former Director of Nursing dated 12-24-21 revealed the following: Resident #65 reported NA #1 came into his room at approximately 5:30am on 12-24-21 and "snatched the covers off of me". He stated the NA told him "I have been a NA for 30 years and I am going to show you to pull [yourself] up." The resident stated in the report the next thing he knew the NA was grabbing onto his right arm and jerking him. He reported he began shaking his arm trying to get the NA to let him go and the next thing he knew NA #1 slapped him in the face causing the bridge of his nose to bleed. The report indicated on assessment of Resident #65 he had fresh reddish-purple bruising on his right forearm down to the top of his wrist and a bruise to the base of his right thumb. Resident #65 also had a fresh abrasion to the bridge of his nose that was no longer bleeding. Report documentation revealed the police were notified on 12-24-21 at 2:10pm. 1a. NA #1 was interviewed by telephone on 2-23-22 at 3:58pm. NA #1 confirmed she was the NA for all of 200 hall including Resident #65 on 12-24-21 during the 11:00pm to 7:00am shift. The NA discussed Resident #65 being agitated most of her shift and around 5:30am she entered Resident #65's room to reposition him in the bed. She explained when she grabbed his draw sheet to reposition him, the resident swung at her, so she grabbed his arms, but the resident continued to swing hitting himself in the face. NA #1 stated she reported the incident to Nurse #1 and Nurse #1 instructed her to stay out of Resident #65's room. She said after she reported the incident, she still had 17 other residents to care for, so she continued her care of the other residents.	F 607	weeks and then monthly times 2 months or until resolved by the Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life-QA Committee and corrective actions initiated as appropriate. The Quality of Life Committee consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinators, Unit Support Nurse, MDS coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Completion = 02/25/2022	

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LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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Review of NA #1's time sheet for 12-24-21 confirmed NA #1's interview revealing she clocked out of work at 7:00am.

A telephone interview occurred with Nurse #1 on 2-23-22 at 4:45pm. Nurse #1 confirmed she was the nurse for Resident #65 on 12-24-21 during the 11:00pm to 7:00am shift. She explained she entered Resident #65's room at approximately 5:45am (12-24-21), she found Resident #65 upset and crying. She stated the resident informed her that NA #1 had slapped him in his face and held his arms down. Nurse #1 said she spoke with NA #1 of the physical abuse allegation then reported the allegation to the DON. She discussed not remembering what the DON told her to do with NA #1 but stated NA #1 continued with her resident assignment and rounds until the end of the shift at 7:00am. Nurse #1 stated she did not think about removing the NA from the floor and said she thought NA #1 only had 1-2 more residents to provide care to. Nurse #1 stated she continued her medication pass entering another resident room and the resident had informed her NA #1 had been rough with her while providing incontinence care. The nurse stated she did not ask the resident any questions, examine the resident or report the information to management and she stated, "I just did not think about it. I was concerned with Resident #65." She also said she could not remember who the other resident was.

The former Director of Nursing (DON) was interviewed by telephone on 2-23-22 at 3:37pm. The DON confirmed she was the DON for the facility on 12-24-21. She discussed receiving a call from Nurse #1 who told her Resident #65 had made an allegation of physical abuse by NA #1.

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She further discussed the allegation involved NA #1 slapping Resident #65 in the face causing an abrasion to the bridge of his nose and holding Resident #65's arms down causing bruising to his right arm. The DON stated she instructed Nurse #1 to remove NA #1 from the hall but not to let the NA leave the building before she arrived. She explained that she had not wanted the NA to have any further resident contact after the allegation was made because it could put other residents at risk for harm. She stated she arrived at the facility around 7:45am and observed NA #1 sitting at the nurse's station writing out her recall of events leading to the allegation of physical abuse. The DON stated she allowed the NA to stay at the nursing station while she went to assess and interview Resident #65. She revealed she had not known that NA #1 continued to provide resident care after the allegation was reported.

The Administrator was interviewed on 2-24-22 at 11:48am. The Administrator stated he was not aware NA #1 continued with her assignment after the allegation of physical abuse was made and did not know why Nurse #1 did not remove her immediately. He stated Nurse #1 knew the abuse policy which indicated an employee was to be removed immediately from the floor and placed in a non-resident area if an allegation of abuse was made.

The facility's Medical Director was interviewed by telephone on 2-24-22 at 2:48pm. The Medical Director stated he would have expected NA #1 to be suspended immediately and escorted out the door.

The Administrator was notified of Immediate Jeopardy on 2-24-22 at 1:46pm.

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" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 12/24/2021, Resident #65 reported to his nurse that his assigned nursing assistant had hit him. At approximately 5:30am on 12-24-21 a Nursing Assistant (NA #1) came into Resident #65's room and "snatched the covers off" and when the resident asked the NA not to snatch his covers off the NA told him that she was going to show him how to reposition himself and grabbed his right arm. Resident #65 stated that he tried to get loose from the NA's grasp and that was when the NA slapped Resident #65 on his face causing the bridge of his nose to bleed. The Director of Nursing was notified by the staff nurse on 12/24/2021.
Resident #65 was assessed immediately on 12/24/2021 by the staff nurse. The nurse noted that the resident had a "fresh reddish-purple bruise on his right forearm down to his wrist, top of right thumb. Also has a fresh abrasion/scab with no bleeding on bridge of nose. No other injuries noted" The Physician and resident responsible party were notified on 12/24/2021 by staff nurse. No new orders were received. The DON instructed Nurse #1 to remove the NA from the floor and have her wait until she arrived at the facility to leave. Nurse #1 stated she could not remember what the DON instructed her to do with the accused NA. Nurse #1 allowed the NA to finish her rounds. The NA clocked out at 7AM on 12/24/2021. The accused NA was suspended, and the agency was notified on 12/24/2021 that the staff member would not be allowed to return.

All residents have the potential to be affected by

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this deficient practice.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 02/23/2022, all current residents that were able to be interviewed, were asked if they had been abused or mistreated by staff. This was completed by the activity director and the health information director. No new allegations of abuse were identified. Also, on 02/23/2022, skin assessments were completed on current residents that were not interviewed. This was completed by the staff nurses. These residents were assessed to identify if there were any sign of abuse such as bruises or scratches of unknown origin. No additional residents were identified.

On 12/24/2021, the staff development coordinator in-serviced all nursing staff on the abuse and prohibition policy. This training was completed for all staff and has been ongoing since 12/24/2021 for new hires.
Additional training began on 02/24/2022 by the Nurse Consultant and Nurse Administration Team. This training will include all contracted, full time, part time, prn - all staff. This training included:
When abuse is suspected or reported, staff must immediately report the suspicion or allegation to the nurse, Administrator, or Director of Nursing.
Facility investigation beginning steps (Take whatever steps are necessary to protect the residents and to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. This includes immediate suspension of

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the accused employee or employees.)
It is imperative that all staff understand that when an allegation of staff to resident abuse is made that the accused staff member must immediately be removed from the floor with no resident contact until the investigation is completed to protect the facility residents.
The Director of Nursing and Nurse Clinical Consultant as well as Facility Administrator will ensure that any staff who does not complete the in-service training by 2/24/2022 will not be allowed to work until the training is completed.
Alleged IJ Removal Date: 2/25/2022

The facility's credible allegation of Immediate Jeopardy was validated on 2-25-22 with interviews with facility staff including nursing staff, dietary and housekeeping. The staff verbalized receipt of education on types of abuse, reporting abuse and removing the accused staff member from any further resident interactions. A sample of residents were interviewed and stated they were questioned about abuse and educated on reporting abuse. Staff education documentation, audits and monitoring were reviewed.

The facility's date of Immediate Jeopardy removal of 2-25-22 was validated.

1b. The facility's initial allegation report for the staff (NA #1) to resident (Resident #65) physical abuse allegation that occurred on 12-24-21 at approximately 5:30 AM revealed it was reported to the state by the Director of Nursing on 12-24-21 at 4:50pm.

Review of the facility's investigation report dated 12-29-21 revealed no documentation that other residents, who had contact with Nursing Assistant

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(NA) #1 after the alleged physical abuse of Resident #65 were interviewed or assessed for injuries.

During a telephone interview with the former DON on 2-23-22 at 3:37pm, the DON indicated she arrived at the facility around 7:45am on 12-24-21 and began completing the initial allegation and investigation of employee to resident physical abuse by NA #1 to Resident #65. She stated she was aware allegations of physical abuse needed to be reported to the state agency within 2 hours. The DON said she believed the Administrator was going to send the initial allegation to the state and did not realize it was not sent until 4:30pm on 12-24-21. She verified there were no interviews conducted with other residents because she believed NA #1 did not have any further contact with the residents after she was made aware of the allegation of physical abuse.

The Administrator was interviewed on 2-23-22 at 9:15am. The Administrator stated he was unaware the initial report of employee to resident physical abuse on 12-24-21 was not faxed to the state agency within the 2 hour requirement. He stated the facility policy was for abuse allegations to be reported to the state agency within 1 hour. The Administrator verified there were no interviews or assessments of the other residents who had contact with NA #1 after the allegation of physical abuse was reported.

The facility's Medical Director was interviewed by telephone on 2-24-22 at 2:48pm. The Medical Director stated he would have expected the DON to assess and conduct interviews with the other residents that NA #1 had contact with to ensure no other residents were physically abused.

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		3/30/22

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F 623	Continued From page 41 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 42 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide in writing of the reason for the discharge to the hospital for 1 of 1 resident reviewed for hospitalizations (Resident #31). Findings included: Resident #31 was admitted to the facility on 8/28/21. He had readmissions from the hospital on 1/14/22 and 2/4/22. The unit manger was interviewed on 2/25/22 at 9:00 AM and he stated when a resident was sent to the hospital, the Responsible Party (RP) was notified by phone. He stated a written notice of transfer was not sent by mail or sent with the resident to the hospital. On 2/25/22 at 9:33 AM the Administrator was interviewed, and he stated he does not notify the resident's RP of discharges in writing. He stated	F 623	F623 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Affected Residents For resident #31 readmitted back to building on 02/04/2022. Corrective Action for Potentially Affected Residents All residents sent to hospital have the potential to be affected by this alleged deficient practice. On 03/21/2022, the	

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F 623	Continued From page 43 the business office may do it. On 2/25/22 an interview was conducted with Nurse #2 at 10:15, and she stated when she sent residents to the hospital, she called the RP to let them know about the transfer and why. She stated a written notice of transfer was not sent with the resident. Nurse #10 was interviewed on 2/25/22 at 10:18 and she stated a notice of transfer was not sent with the resident to the hospital. She stated she had called the RP to make them aware of the transfer and tell them why they are going. A business office staff member was interviewed on 2/25/22 at 11:10 AM and she stated she was not responsible for sending transfer notices to the resident's RP. On 2/25/22 at 11:48 AM an interview with the Corporate Nurse Consultant was completed. She stated written notice of transfers were not sent with the resident to the hospital or mailed to the resident's RP. She stated a packet was being put together to send with the resident to the hospital to include a written notice of transfer.	F 623	Administrator audited the last 48hrs of discharges/transfers to hospitals. Administrator ensured all resident identified in audit received written noticed. This was completed on 03/22/2022. Systemic Changes On 03/17/2022 the Quality Assurance Nurse Consultant began in-servicing all current Licensed Nurses and Department Managers. This in-service included the following topics: " Transfer Discharge to Hospital written notification The Director of Nursing will ensure that any staff who has not received this training by 03/30/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and Department Managers, will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Hospital Written Transfer Notice. The monitoring will include reviewing PCC document of notice sent. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development	

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F 623	Continued From page 44	F 623	Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Compliance: 03/30/2022	
F 636 SS=E	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 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.	F 636		3/30/22

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F 636	Continued From page 45 (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 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 conduct an annual comprehensive assessment for 10 of 63 residents reviewed for Resident Comprehensive Assessments (Residents #487, #488, #335, #136, #490, #336, #587, #491, #135, and #7). Findings included: 1. Resident # 487 was admitted to the facility	F 636	F636 □ Comprehensive Assessment and Timing Corrective actions have been taken for all affected residents as follows: ¿ Resident #487: Assessment with ARD 02/07/2022 was completed on 03/08/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/09/2022 in MDS Batch #2031.	

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F 636	Continued From page 46 1/31/22 with diagnoses including hypertension and hyperlipidemia. On 2/22/22 Resident #487s admission comprehensive assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 2/7/22 was observed in the electronic medical record as "open" and not completed. 2. Resident #488 was admitted to the facility on 2/11/22 with diagnoses that included diabetes mellitus and heart failure. On 2/22/22 Resident #488's admission comprehensive assessment with an ARD of 2/18/22 was observed in the electronic medical record as "open" and not completed. 3. Resident #335 was admitted to the facility on 2/4/22 with diagnoses that included hyperthyroidism and hypotension. On 2/22/22 Resident #335's admission comprehensive assessment with an ARD of 2/11/22 was observed in the electronic medical record as "open" and not completed. 4. Resident #136 was admitted to the facility on 2/7/22 with diagnoses that included chronic kid chronic kidney disease and hyperlipidemia. On 2/22/22 Resident #136's admission comprehensive assessment with an ARD of 2/13/22 was observed in the electronic medical record as "open" and not completed. 5. Resident #490 was admitted to the facility on 2/1/22 with diagnoses that included hypertension	F 636	¿ Resident #488: Assessment with ARD of 02/18/2022 was completed on 02/24/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 02/25/2022 in MDS Batch #2021. ¿ Resident #335: Assessment with ARD of 02/11/2022 was completed on 02/09/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/08/2022 in MDS Batch #2030. ¿ Resident #136: Assessment with ARD of 02/13/2022 was completed on 02/23/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/09/2022 in MDS Batch #2031. ¿ Resident #490: Assessment with ARD of 02/08/2022 was completed on 03/04/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/11/2022 in MDS Batch #2033. ¿ Resident #336: Assessment with ARD of 02/10/2022 was completed on 02/10/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 02/25/2022 in MDS Batch #2021. ¿ Resident #587: Assessment with ARD of 02/05/2022 was completed on 02/05/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/04/2022 in MDS Batch #2028. ¿ Resident #491: Assessment with ARD of 02/17/2022 was completed on 02/17/2022 by the facility Minimum Data	

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F 636	Continued From page 47 and depression. On 2/22/22 Resident #490's admission comprehensive assessment with an ARD of 2/8/22 was observed in the electronic medical record as "open" and not completed. 6. Resident #336 was admitted to the facility on 2/8/22 with diagnoses that included diabetes mellitus and chronic kidney disease. On 2/22/22 Resident #336's admission comprehensive assessment with an ARD of 2/10/22 was observed in the electronic medical record as "open" and not completed 7. Resident #587 was admitted to the facility on 1/31/22 with diagnoses that included metabolic encephalopathy (a problem in the brain due to a chemical imbalance in the blood) and anemia. On 2/22/22 Resident #587's admission comprehensive assessment with an ARD of 2/5/22 was observed in the electronic medical record as "open" and not completed. 8. Resident #491 was admitted to the facility on 2/10/22 with diagnoses that included dementia and diabetes mellitus. On 2/22/22 Resident #491's admission comprehensive assessment with an ARD of 2/17/22 was observed in the electronic medical record as "open" and not completed. 9. Resident #135 was admitted to the facility on 1/24/22 with diagnoses that included diabetes mellitus and hyperlipidemia.	F 636	Set nurse and was submitted/accepted into state database on 02/28/2022 in MDS Batch #2022. ¿ Resident #135: Assessment with ARD of 01/28/2022 was completed on 02/25/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/03/2022 in MDS Batch #2026. ¿ Resident #7: Assessment with ARD of 01/11/2022 was completed on 03/04/2022 by the facility Minimum Data Set nurse and was submitted/accepted into state database on 03/07/2022 in MDS Batch #2029. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all Comprehensive Minimum Data Set assessments that are currently in progress or currently due was completed in order to identify any resident with a comprehensive assessment that has either been missed or has not been completed within the required timeframe. The Master Minimum Data Set Scheduler in Point Click Care was utilized to perform this audit. This audit was completed on 03/17/2022 by the Regional Minimum Data Set Consultant. Audit Results A total of 18 residents currently have a comprehensive Minimum Data Set	

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F 636	Continued From page 48 On 2/22/22 Resident #135's admission comprehensive assessment with an ARD of 1/28/22 was observed in the electronic medical record as "open" and not completed. 10. Resident #7 was admitted to the facility on 1/11/21 with diagnoses that included diabetes mellitus and chronic kidney disease. On 2/22/22 Resident #7's annual comprehensive assessment with an ARD of 1/13/22 was observed in the electronic medical record as "open" and not completed. An interview was conducted with the MDS (Minimum Data Set) Nurse on 02/22/22 11:44 AM revealed she started working at the facility about 4 weeks ago and noticed the facility's MDS assessments were behind dating back to the beginning of January 2022. The MDS nurse stated the facility's position of MDS Nurse had been vacant prior to her being hired which contributed to the late MDS assessments. During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations.	F 636	assessment in progress or due. " 16 of 18 residents identified as having comprehensive assessment that remains within the required timeframe for completion, having a due date or completion date that is after the date of this audit (03/17/2022). " 2 of 18 resident were identified as having a comprehensive assessment that is in progress, and has not been completed and is past the due date for completion. All comprehensive assessments identified as being in progress and having not been completed by the required due date will be completed and submitted to the state database no later than 03/25/2022 by the facility Minimum Data Set Nurse. Systemic Changes On 03/18/2022, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a	

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significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment.

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day one if:

" this is the resident□s first time in this facility, OR

" the resident has been admitted to this facility and was discharged return not anticipated, OR

" the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).

The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later

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than. The CAA(s) completion date (item V0200B2) must be no later than day 14. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
The Significant Change Status Assessment is a comprehensive

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F 636	Continued From page 51	F 636	assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT□s determination was made that the resident had a significant change. The ARD must be less than or equal to 14 days after the IDT□s determination that the criteria for an SCSA are met (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the facility□s compliance with ensuring that comprehensive Minimum Data Set assessments are scheduled and completed within required timeframes as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled Comprehensive	

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F 636	Continued From page 52	F 636	Assessments and Timing Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/21/2022	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 9 of 9 residents reviewed for	F 638	F638 Quarterly Assessment at Least Every 3 Months Corrective Action Minimum Data Set assessments for	3/30/22

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quarterly MDS assessments timing. (Resident #10, Resident #13, Resident #6, Resident #11, Resident #29, Resident #14, Resident #4, Resident #9, and Resident #28)

Findings included:
1. Resident #10 was admitted to the facility on 5/4/21.

Record review revealed Resident #10 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/28/22.

During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #10 was not completed within the 14 day time period from the ARD.

During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations.

2. Resident #13 was admitted to the facility on 11/9/16.

Record review revealed Resident #13 had an

affected residents that were identified as not being completed within the required timeframe were completed and submitted to the state database as follows:
" Resident #10: MDS with Assessment Reference Date of 1/28/2022 was completed on 3/7/2022 and was submitted and accepted into state database on 3/8/2022 in MDS Batch #2030.
" Resident #13: MDS with Assessment Reference Date of 1/14/2022 was completed on 3/5/2022 and was submitted and accepted into state database on 3/7/2022 in MDS Batch #2029.
" Resident #6: MDS with Assessment Reference Date of 1/9/2022 was completed on 2/23/2022 and was submitted and accepted into state database on 2/24/2022 in MDS Batch #2020.
" Resident #11: MDS with Assessment Reference Date of 1/15/2022 was completed on 3/7/2022 and was submitted and accepted into state database on 3/8/2022 in MDS Batch #2030.
" Resident #29: MDS with Assessment Reference Date of 1/14/2022 was completed on 3/4/2022 and was submitted and accepted into state database on 3/7/2022 in MDS Batch #2029.
" Resident #14: MDS with Assessment Reference Date of 1/17/2022 was completed on 3/9/2022 and was submitted and accepted into state database on 3/9/2022 in MDS Batch

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F 638	Continued From page 54 incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/14/22. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #13 was not completed within the 14-day time period from the ARD. During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations. 3. Resident #6 was admitted to the facility on 3/25/19. Record review revealed Resident #6 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/9/22. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous	F 638	#2031. " Resident #4: MDS with Assessment Reference Date of 1/8/2022 was completed on 3/4/2022 and was submitted and accepted into state database on 3/7/2022 in MDS Batch #2029. " Resident #28: MDS with Assessment Reference Date of 1/24/2022 was completed on 3/14/2022 and was submitted and accepted into state database on 3/15/2022 in MDS Batch #2035. Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 03/17/2022, the Minimum Data Set Consultant conducted a 100% audit on all current residents in order to determine if they have had a Minimum Data Set Assessment completed at least once every 3 months with the Assessment Reference Date not being greater than 92 days since prior assessment□s reference date □ AND - to determine if the assessment was completed by the required due date. The results of this audit were: " 66 of 93 residents identified as having a Minimum Data Set assessment completed that met the requirement of the Assessment Reference Date not being greater than 92 days since prior assessment□s reference date. " 27 of 93 residents were identified as	

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MDS nurse. She concluded the MDS for Resident #6 was not completed within the 14-day time period from the ARD.

During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations.

4. Resident #11 was admitted to the facility on 10/31/18.

Record review revealed Resident #11 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/15/22.

During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #11 was not completed within the 14-day time period from the ARD.

During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the

having been admitted to the facility less than 90 days ago and have not come due for a quarterly Minimum Data Set assessment yet.

o 19 of 93 residents identified as having had a Minimum Data Set assessment completed within the required time frame at least once every three months and was completed by the required due date.
o 42 of 93 residents identified as having a Minimum Data Set that had an Assessment Reference Date within 92 days of the prior assessment; however, was not completed by the required due date. At the time of this audit all of these assessments have been completed and submitted.
o 32 of 93 residents were identified as having a current Minimum Data Set assessment that is in progress and not due to be completed at the time of this audit.

Systemic Changes

On 03/18/2022, the Minimum Data Set Nurse Consultant conducted in-service training for the facility Minimum Data Set Nurse(s) on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education emphasized that all residents must have no more than 92 days between Assessment Reference Dates of each Minimum Data Set assessment (Admission, Annual,

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F 638	Continued From page 56 scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations. 5. Resident #29 was admitted to the facility on 6/23/20. Record review revealed Resident #29 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/14/22. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #29 was not completed within the 14-day time period from the ARD. During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations. 6. Resident #14 was admitted to the facility on 10/9/20. Record review revealed Resident #14 had an incomplete quarterly MDS with an assessment	F 638	Quarterly, Significant Change). Focus was also placed on the importance of ensuring that all Minimum Data Set assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual. Monitoring The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements; The Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 6 months to validate whether or not they have had an Minimum Data Set assessment completed at least once every 3 months per the Resident Assessment Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled Quarterly Completion of Minimum Data Set Assessments. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health	

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F 638	Continued From page 57 reference date (ARD, the last day of the look-back period) of 1/17/22. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #14 was not completed within the 14-day time period from the ARD. During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations. 7. Resident #4 was admitted to the facility on 6/15/16. Record review revealed Resident #4 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/8/22. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident	F 638	Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/21/2022	

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F 638	Continued From page 58	F 638		

#4 was not completed within the 14-day time period from the ARD.

During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations.

8. Resident #9 was admitted to the facility on 04/26/2021.
Record review revealed Resident #9 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 1/26/2022.

During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and had been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #9 was not completed within the 14 day time from the ARD.

During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments

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F 638	Continued From page 59 should be completed timely in accordance with the regulations. 9. Resident #28 was admitted to the facility on 11/12/2020. Record review revealed Resident #28 had an incomplete quarterly MDS with an assessment reference date (ARD, the last day of the look-back period) of 01/24/2022. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated she was new and had been doing MDS assessments for the past 7 days. She further stated she was working on catching up minimum data set assessments that had not been completed on time and left by the previous MDS nurse. She concluded the MDS for Resident #28 was not completed within the 14 day time from the ARD. During an interview 2/22/22 at 2:21 PM the Administrator stated he had been made aware from his corporate compliance officer last night that they need to complete a plan of correction for late minimum data set assessments. He stated they were in the middle of trying to identify the scope of the issues and had not completed their audit yet. He concluded MDS assessments should be completed timely in accordance with the regulations.	F 638		
F 641 SS=D	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:	F 641		3/30/22

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F 641	Continued From page 60 Based on observations, record review, and staff interviews the facility failed to accurately code the ostomy status of a resident on an admission Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident #10) reviewed for activities of daily living care. Findings included: Review of Resident #10's hospital discharge summary dated 5/3/21 revealed Resident #10 did not have an ostomy. Resident #10 was admitted to the facility on 5/4/21. Her active diagnoses included vascular dementia, hypertension, and hyperlipidemia. Resident #10's admission MDS dated 5/11/21 revealed she was assessed to have an ostomy (including urostomy, ileostomy, and colostomy). During observation on 2/21/22 at 10:46 AM Resident #10 was observed to not have an ostomy. During an interview on 2/21/22 at 11:35 AM Nurse #10 stated Resident #10 did not have an ostomy and was not aware of the resident ever having an ostomy. During an interview on 2/22/22 at 1:59 PM MDS Nurse #1 stated to her knowledge Resident #10 did not have an ostomy and the MDS dated 5/11/21 was incorrect regarding ostomy status. During an interview on 2/22/22 at 2:21 PM the Administrator stated Resident #10 did not have an ostomy and the MDS dated 5/11/21 was incorrect.	F 641	F641 Accuracy of Assessments For resident #10 a corrective action was obtained on 02/22/2022 by modifying and correcting MDS assessment for assessment reference date of 05/11/2021. Coding of question H0100C (Ostomy) was corrected to accurately reflect that resident did not have an ostomy present during the specified lookback timeframe. Correction was completed by Regional MDS Consultant on 02/22/2022. Corrected MDS was re-submitted and accepted into state database on 02/23/2022 in MDS Batch #2019. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who have had an MDS completed during the past three months (12/13/2021-03/15/2022) was completed in order to identify all residents who were coded as having an ostomy in question H0100C. This audit was conducted by the Regional MDS Consultant. The residents identified as having been coded with an ostomy were further reviewed to determine if coding is accurate. Audit Results: 3 of 4 residents were accurately coded for question H0100C (ostomy). 1 of 4 residents was inaccurately coded for question H0100C (ostomy). All residents who were identified to have inaccurate coding of H0100C had the affected MDS modified and corrected by the Regional MDS Consultant on	

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03/16/2022. Corrected MDS was re-submitted and accepted into state database on 03/17/2022 in MDS Batch #2037.
Systemic Changes

On 03/18/2022, the Regional Minimum Data Set Nurse Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record during the assessment process and before coding the MDS assessment. Special emphasis was highlighted on:
" Section H0100C: Coding of the presence of an ostomy (including: colostomy, urostomy, and ileostomy).
The education emphasized the importance of examining the resident in order to determine the presence of an ostomy. It also detailed the importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes, orders, etc. in order to determine the presence of an ostomy. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Director of Nursing or designee will begin auditing the coding of MDS item H0100C (ostomies) using the quality

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F 641	Continued From page 62	F 641	assurance audit tool entitled Accurate Minimum Data Set Coding Audit Tool-H0100C. This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/21/2022	
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-	F 655		3/30/22

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F 655	Continued From page 63 (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 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 observations, interviews with residents and facility staff and record review the facility failed to develop a base line care plan within 48 hours of admission to address the needs of the residents for 3 (Residents #135, #136, & #5) of 3 residents reviewed and failed to provide a summary of the baseline care plan to the resident or responsible party for 2 (Residents #135 & #136) of 3 residents reviewed for baseline care	F 655	F655 Baseline Care Plan Corrective action for affected residents: Resident #136: Resident has already discharged from facility; therefore, corrective action unable to be completed. Resident #135: Baseline care plan reviewed with resident on 03/18/2022 by the facility Minimum Data Set nurse. Resident maintained a signed copy of the	

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F 655	Continued From page 64 plans. The findings included: 1) Resident #135 was admitted to the facility on 1/24/22 with diagnoses which included splenectomy, diabetes, and chronic obstructive lung disease. The care plan for Resident #135 dated 1/25/22 revealed only 2 care areas. The care areas were potential nutritional problems related to receiving a therapeutic diet and had an actual fall with risks for further (falls). On 2/22/22 at 12:48 PM Resident #135 stated she did not know what the plan for discharge was. She said she had not received any written information about her plan of care. She stated she had a folder which contained all the information she had received from the facility. She opened the folder which revealed no care plan information was provided. The Administrator was interviewed on 2/25/22 at 9:40 AM. He stated there should be a baseline care plan to address all the resident's needs and not just 1 or 2 care areas. 2) Resident #136 was admitted to the facility on 2/7/22 with diagnoses which included multiple fractures of the pelvis, rheumatoid arthritis, stage 4 chronic kidney disease, irritable bowel syndrome and gastro-esophageal reflux disease. A review of the care plan dated 2/22/22 revealed one focus area. This focus area was diagnosis of hypothyroidism and receiving Synthroid daily with risk for adverse side effects.	F 655	baseline care plan. The facility also maintained a signed copy of the baseline care plan. Resident #5: Resident has already discharged from facility; therefore, corrective action unable to be completed. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be impacted by the alleged deficient practice. A 100% audit of all current residents who have been admitted to the facility within the last 30 days was completed in order to determine if the baseline care plan requirement was met for each of them. Audit was completed by Regional Minimum Data Set Consultant on 03/17/2022. The results of this audit were: 11 of 11 residents were identified as having not had the baseline care plan requirement met. All residents who were identified as not having had the Baseline Care Plan requirement met will have their Baseline Care Plan initiated and reviewed with them by a facility nursing manager. Each of the residents will receive a copy of the baseline care plan that has been signed and dated by themselves and the reviewing nurse. This will be completed no later than 03/25/2022.	

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F 655	Continued From page 65 On 2/22/22 at 12:30 PM Resident #136 stated she had not received any written information about a care plan. She stated the physical therapist had discussed a plan for therapy but no one else had discussed her plan of care or what she needed for discharge. The Administrator was interviewed on 2/25/22 at 9:40 AM. He stated there should be a baseline care plan to address all the resident's needs and not just 1 or 2 care areas. He added the baseline care plan should be completed within 48 hours of admission. 3. Resident #5 was admitted to the facility on 1/12/22 and discharged on 1/20/22. Review of Resident #5's electronic medical record revealed he had diagnoses which included: blindness, Diabetes Mellitus, dependence on renal dialysis, long term current use of anticoagulants, congestive heart failure, and anxiety. Review of Resident #5's care plan initiated on 1/17/22 revealed one focus area for nutrition. The care plan did not include focus, goals, or interventions for the resident's other medical conditions. An interview with MDS Nurse #1 on 2/23/22 at 10:21 AM revealed she was new to the facility and did not know why Resident #5's care plan had not been initiated with focus areas relevant to the resident. An interview with the Administrator on 2/24/22 at 10:30 AM revealed he expected care plans to be initiated for resident centered care areas. He	F 655	Systemic Changes On 03/18/2022, the Regional Minimum Data Set Nurse Consultant provided education to the Minimum Data Set Coordinator and any member of the Interdisciplinary Team who participates in the care planning process including care planning meetings. This education reviewed CMS requirements for ensuring that the Baseline Care Plan requirement be met for all newly admitted residents. Baseline Care Plan Requirement: 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: 1. Be developed within 48 hours of a resident□s admission. 2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: ¿ Initial goals based on admission orders. ¿ Physician orders. ¿ Dietary orders. ¿ Therapy services. ¿ Social services ¿ PASARR recommendation, if applicable. Within 48 hours of admission to the facility, the facility must develop and	

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F 655	Continued From page 66 stated due to new staffing and staffing changes, Resident #5's care plan had not been created as it should have been.	F 655	implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR ¿483.21(a)). In many cases, interventions to meet the resident□s needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident□s problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days). The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing, Administrator or designee will review 5 random residents who have been admitted to the facility during the past 30 days in order to determine if the Baseline Care Plan was completed during the required timeframe. This audit will be completed using the Quality Assurance audit tool entitled Baseline Care Plan Completion Audit. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of	

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F 655	Continued From page 67	F 655	Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/25/2022	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/30/22

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F 656	Continued From page 68 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive individualized care plan for 1 of 1 resident (Resident #65) reviewed for hospice services. Findings included: Resident #65 was admitted to the facility on 9-22-21 with multiple diagnoses that included stage 3 chronic kidney disease, congestive heart failure and peripheral vascular disease. The significant change Minimum Data Set (MDS) dated 12-27-21 revealed Resident #65 was cognitively intact and was coded for hospice services. Resident #65's care plan dated 1-31-22 revealed no goals or interventions for hospice services.	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective Action: Resident #65: Care plan reviewed and revised on 02/24/2022 by the facility Minimum Data Set Nurse. The care plan was revised to include that the resident is receiving hospice services as well as hospice related goals and interventions. Identification of other residents who may be involved with this practice: All current residents who are receiving hospice services have the potential to be affected by the alleged deficient practice. On 3/16/2022 the Regional Minimum Data Set Consultant completed a 100% audit of all current residents who are receiving hospice services. The care plan for each	

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F 656	Continued From page 69 During an interview with the Corporate Nurse Consultant on 2-24-22 at 1:30pm, The Nurse Consultant confirmed Resident #65 was not care planned for hospice services and she stated the resident's care plan should have reflected that he was receiving hospice services. The MDS Nurse was interviewed on 2-24-22 at 2:00pm. The MDS Nurse confirmed Resident #65 was not care planned for hospice services but was an active hospice resident. The nurse discussed if a resident was on hospice services, then their care plan should reflect goals and interventions for hospice services. On 2-25-22 at 11:30am an interview occurred with the Administrator. The Administrator explained department managers meet within 48 hours of a resident admission to ensure care plans are current and areas are addressed. He stated Resident #65's care plan for hospice services was overlooked but expected the care plans reflect the most current information.	F 656	resident who is currently receiving hospice services was audited to validate that it reflects hospice care and hospice related goals and interventions. Audit Results: 3 of 4 residents had hospice services appropriately reflected on care plan. 1 of 4 residents did not have hospice services reflected on care plan. Resident whose care plan did not reflect hospice services had a revision of care plan completed and hospice services related goals and interventions were added. This revision was completed by the Regional Minimum Data Set Consultant on 03/16/2022. Systemic Changes: On 3/18/2022 education was provided to the facility Minimum Data Set Nurse by the Regional Minimum Data Set Consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to	

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F 656	Continued From page 70	F 656	refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be reviewed and revised in order to include when resident□s condition changes, as well as when they begin receiving Hospice Services. This in service was completed by 3/18/2022. This education has been incorporated into the orientation for all new Minimum Data Set nurses. Monitoring: To ensure compliance, The Director of Nursing or designee will audit care plans for residents who are receiving hospice services in order to ensure that the care plans for these residents reflect their current hospice care, hospice goals and interventions. This audit will be completed using the Quality Assurance audit tool entitle Comprehensive Care Plan Development Audit Tool (Hospice). This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinator to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to	

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F 656	Continued From page 71	F 656	the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 3/16/2022	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews the facility failed to follow a physician's order to get a resident out of bed (Resident #10) and failed to obtain a chest x-ray (CXR) as ordered by the physician (Resident #9) for 2 of 5 residents reviewed for professional standards. Findings included: 1. Resident #9 was admitted to the facility on 04/26/2021 with diagnoses including diabetes and dementia.	F 684	F684 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	3/30/22

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F 684	Continued From page 72 A review of his quarterly Minimum Data Set (MDS) assessment dated 08/03/2021 revealed he was severely cognitively impaired. He required the extensive assistance of one person for bed mobility. He was dependent on one person for bathing. A review of a physician's order for Resident #9 dated 10/07/2021 revealed complete blood count (CBC). A review Resident #9's CBC results dated 10/08/2021 revealed his white blood cell count (WBC) result was 20.6 thousand per cubic milliliter (normal range is 4.9-11.1-an elevated WBC count can be an indicator of infection). A review of a nursing progress note for Resident #9 dated 10/08/2021 at 7:12 PM revealed his physician was notified of his elevated WBC count. A review of a physician's order dated 10/08/2021 revealed CXR for elevated WBC. A review of Resident #9's medical record did not reveal evidence this CXR was completed. On 02/23/2022 at 8:14 AM an interview with Unit Manager (UM) #1 indicated he notified Resident #9's physician of his elevated WBC count by telephone on 10/08/2021. He stated Physician #1 gave him a telephone order for a CXR to be completed. UM #1 went on to say he entered this order into the computer but did not call the mobile x-ray provider to notify them of the order. He stated the normal process was for the nurse receiving a physician's order for an x-ray to call the mobile x-ray provider to notify them of the	F 684	Corrective Action for Affected Residents For resident #9 □ On 02/23/2022 Unit Manager informed Physician that Xray was not completed before resident was sent to hospital for skin infection. No new orders received. For resident #10 □ On 02/22/2022 Nurse #10 notified Physician of safety concern related to Resident #10 leaning in Geri chair. New order received to hold order for in Geri chair every other day until therapy can evaluate for adaptive equipment to assist with trunk support. Corrective Action for Potentially Affected Residents Resident #9 - All residents have X-ray orders have the potential to be affected by this alleged deficient practice. On 03/16/2022 the Nurse Managers audited all current residents who have had a Xray orders within the past 90 days. This was completed on 03/18/2022. Resident #10 □ All residents with orders to get up out of bed have the potential to be affected by this alleged deficient practice. On 3/17/2022 the Nurse Managers reviewed all residents that have orders to get out of bed and made each nurse aware of the physician order that must be followed. Systemic Changes Resident: #9 - On 03/02/2022 the Quality Assurance Nurse Consultant and designee began in-servicing all current licensed nurses on the following: " Following Physician orders □ Resident #10 " How to follow up on Xray/Diagnostic Imaging #9	

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F 684	Continued From page 73 order. He further indicated he could not find evidence in Resident #9's medical record to indicate his CXR had been completed. On 02/23/2022 1:20 PM a telephone interview with Physician #1 indicated although Resident #9 was not having any respiratory issues, he ordered the CXR for Resident #9 to determine the source of his elevated WBC count. He stated Resident #9 subsequently developed a skin infection on 10/09/2021 which likely was the cause of the elevated WBC count. He stated although this would not have been seen on a CXR and would not have changed Resident #9's treatment or outcome, if he ordered a CXR for a resident he expected it to be done. On 02/24/2022 at 2:19 PM an interview with the Corporate Nurse Consultant indicated if Resident #9 had a physician's order for a CXR, the nurse receiving the order from the physician should have called the mobile x-ray provider to schedule it. 2. Resident #10 was admitted to the facility on 5/4/21. Her active diagnoses included vascular dementia, hypertension, and hyperlipidemia. Resident #10's minimum data set assessment dated 10/31/21 revealed she was assessed as severely cognitively impaired. Transferring activity only occurred once or twice during the lookback period. Resident #10 was ordered on 1/11/22 to get out of bed every other day for a few hours and be placed in the TV room. Resident #10's MAR for February 2022 revealed she was documented to have gotten out of bed	F 684	The Director of Nursing will ensure that any license nurse who has not received this training by 3/30/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all license nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance Resident: #9 -The Unit Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring residents with orders for X-rays. The monitoring will include reviewing Point Click Care. Resident #10- The Unit Manager will also monitor for residents that have orders to get out off bed. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Compliance: 03/30/2022	

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F 684	Continued From page 74 by Nurse #10 on the 2nd, 8th, 12th, 16th, and 22nd. During observation on 2/22/22 at 9:05 AM, 11:27 AM, 1:05 PM, 2:31 PM, and 3:30 PM Resident #10 was observed to be in bed. During an interview on 2/22/22 at 3:38 PM Nurse #10 stated Resident #10 did not get out of bed those days she had checked the MAR as the order being complete. She stated needed to review that order as it had not been followed those days because she must have not paid attention to that order and just checked it as complete. She further stated she did not believe Resident #10 was appropriate for getting up in a chair as the way she would position herself in a geri chair would cause her to lean over the side of the chair and put her at risk for skin tears and falls. She concluded the order would need to be clarified and she had not noticed that order until it was brought to her attention now. During an interview on 2/22/22 at 3:52 PM the Corporate Nurse Consultant stated physician orders where to be followed or clarified if there were any concerns with the order. She concluded this should have been done for Resident #10.	F 684		
F 686 SS=E	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		3/30/22

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F 686	Continued From page 75 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 review, observation, staff and Physician interview, the facility failed to provide wound care treatment as ordered for 1 of 4 residents (Resident #39) reviewed for pressure ulcers. Findings included: 1.Resident #39 was admitted to the facility on 6-15-20 with multiple diagnoses that included a stage 4 pressure ulcer to the sacrum. The significant change Minimum Data Set (MDS) dated 12-4-21 revealed Resident #39 was severely cognitively impaired and was coded as having one stage 4 pressure ulcer. Resident #39's care plan dated 2-9-22 revealed a goal that her pressure ulcer would show signs of healing and remain free from infection. The interventions for the goal were in part, administer treatments as ordered and monitor for effectiveness. Physician order dated 10-26-21 revealed an order for Resident #39's stage 4 sacrum pressure ulcer to be cleaned with wound cleanser, apply calcium alginate with silver then apply a foam dressing daily on day shift.	F 686	F686 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Affected Residents For resident # 39 □ Resident #39 wounds assessed on 02/22/2022 by Wound Care Physician no negative outcomes noted related to alleged deficient practice. Corrective Action for Potentially Affected Residents All resident with active wound care orders have the potential to be affected by this alleged deficient practice. On 02/22/2022 Wound Care Nurse and Wound Care Physician audited all current residents with wound care orders. This was accomplished by formulating a list of wound care orders and rounding throughout the facility. No negative outcome was identified by this alleged	

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F 686	Continued From page 76 Review of Resident #39's Treatment Administration Record (TAR) for January 2022 revealed there was no documentation of wound care being completed for 11 of the 31 days (January 1, 2, 3, 8, 11, 15, 16, 18, 22, 29, and 30). Resident #39's TAR was reviewed from 2-1-22 to 2-22-22 and revealed no documentation that wound care had been completed for 4 of the 22 days (February 6, 12, 13, and 21). Observation of wound care occurred on 2-22-22 at 4:55pm with Nurse #13 (Wound Care Nurse) and the Wound Care Physician. Resident #39's wound was clean with a scant amount of bloody drainage. No signs of infection were observed. Nurse #13 was observed to clean and dress the wound per the Physician orders. The Wound Care physician was interviewed on 2-22-22 at 5:00pm. The Physician stated he expected staff to document when the wound care was completed, and a progress note written if the wound care was unable to be completed. During an interview with Nurse #13 on 2-24-22 at 10:20am, the nurse confirmed she worked 1-15-22, 1-16-22, 1-30-22, and 2-21-22 but explained on those days she was not assigned to perform wound care and had been assigned to another part of the building to pass medications. Nurse #13 stated the nurses working the unit would have been responsible for completing Resident #39's wound care. Nurse #14 was interviewed on 2-24-22 at 10:50am. The nurse confirmed she was responsible for completing Resident #39's wound	F 686	deficient practice. This process was completed on 02/22/2022. Systemic Changes On 03/17/2022 the Quality Assurance Nurse Consultant and designee began in-servicing all current licensed nurses. This in-service included the following topics: " Following physician orders (to include wound care orders) The Director of Nursing will ensure that any licensed nurse who has not received this training by 03/30/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Following Physician Orders (Wound Care). The monitoring will include reviewing Medication Administration Audit report. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary	

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F 686	Continued From page 77 care on 1-8-22, 1-18-22, and 2-6-22. She stated she did not know why she had not documented that the wound care had been completed on the TAR but then stated she could not remember if she had completed the wound care. Nurse #14 also confirmed there was no documentation in the nursing notes if the wound care had been completed. An interview with Nurse #2 occurred by telephone on 2-24-22 at 1:47pm. The nurse confirmed she was responsible for completing the wound care on Resident #39 on 1-1-22, 1-2-22, 1-11-22, 1-15-22, 1-16-22, 1-29-22, 1-30-22, 2-12-22, 2-13-22, and 2-21-22. The nurse explained she had completed wound care on some of those days but did not document on the TAR because she was busy and on the other days, she did not complete the wound care because she thought the Wound Care Nurse (Nurse #13) would be completing Resident #39's wound care. She stated she can not remember what days she completed the wound care and confirmed there was not documentation in the nursing note. The Administrator was interviewed on 2-25-22 at 11:30am. The Administrator confirmed the hall nurses were responsible for the wound care of residents when there was not a Wound Care Nurse available and expected staff to complete wound care as ordered. He explained he thought there was a lack of investment to the residents care due to the facility needing to use agency nurses.	F 686	Manager and Social Worker. Date of Compliance: 03/30/2022	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		3/30/22

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F 690	Continued From page 78 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to prevent a urinary catheter bag from encountering the floor to reduce the risk of infection or injury. This	F 690	F690 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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(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 690	Continued From page 79 occurred for 1 of 1 resident (Resident #77) reviewed for urinary catheter. Findings included: Resident #77 was admitted to the facility on 12-7-21 with multiple diagnoses that included encounter for fitting and adjustment of urinary device. Resident #77's care plan dated 12-29-21 revealed a goal that he would remain free from catheter related trauma. The interventions for the goal were in part, check tubing for kinks, leg band to secure catheter, position catheter bag and tubing below the level of the bladder, provide catheter care every shift. The quarterly Minimum Data Set (MDS) dated 1-28-22 revealed Resident #77 was cognitively intact and was coded for an indwelling catheter. On 2-22-22 at 8:55am an observation was made of Resident #77's catheter bag under the bed on the floor with one of the wheels of the bed on top of the catheter bag. An observation occurred on 2-22-22 at 12:00pm of Resident #77's catheter bag. The observation revealed the catheter bag was on the floor under the bed. Nursing Assistant (NA) #4 was interviewed on 2-22-22 at 12:05pm. NA #4 confirmed she was the NA caring for Resident #77. She discussed checking the resident's catheter twice during an 8-hour shift and that she checks the catheter when she begins her shift and at the end of the shift. NA #4 stated she had not looked at	F 690	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Affected Residents For resident # 77 catheter and catheter bag assessed by Unit Manager on 03/02/2022. Interdisciplinary Team (IDT) review Catheter bag placement related to resident being in a low bed. IDT Team decided to place catheter bag into a protective bag cover. Corrective Action for Potentially Affected Residents All residents have the potential to be affected by this alleged deficient practice. On 03/02/2022, the Unit Manager audited 100% of all catheter bags for placement and positioning. No other bags noted on resident floors. This was completed on 03/05/2022. Systemic Changes On 03/02/2022 the Quality Assurance Nurse Consultant and designee began in-servicing all current Licensed Nurses, Med Aides, and CNA□s. This in-service included the following topics: " Caring for a resident with a Urinary Catheter Bag The Director of Nursing will ensure that any Nursing staff who has not received this training by 03/30/2022 will not be allowed to work until the training is completed. This information has been	

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	345519	A. BUILDING _____ B. WING _____	C 02/25/2022

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F 690	Continued From page 80 Resident #77's catheter bag that morning but had planned on looking at during care. She confirmed Resident #77's catheter bag was on the floor under the bed, and she stated, "I think it falls off when I reposition his over the bed table." NA #4 said she usually did not check the catheter bag placement after repositioning the over bed table. During an interview with Nurse #2 on 2-22-22 at 12:15pm, the nurse confirmed she was the nurse for Resident #77. She discussed checking on his catheter once a shift, usually during medication pass. She confirmed Resident #77's catheter bag was on the floor during her morning medication pass and that she placed it back on the bed frame. Nurse #1 discussed not understanding how the catheter bag continued to be on the floor since Resident #77 did not move enough to knock it off the bed frame. She also explained she would speak with NA #4 since it was the NA's responsibility to ensure the resident's catheter bag remained off the floor. An observation of Resident #77's catheter bag occurred on 2-23-22 at 9:10am. The observation revealed the catheter bag was laying on the floor next to the resident's bed. A telephone interview with the facility's Medical Director occurred on 2-24-22 at 2:48pm. The Medical Director stated the catheter bag should have remained off the floor. He explained the chance for infection was low due to the catheter bag having a closed system, but he stated he would be concerned about the resident being uncomfortable and the catheter pulling and possibly causing injury. The Administrator was interviewed on 2-25-22 at	F 690	integrated into the standard orientation training for all Nursing Staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Unit Managers will monitor this issue using the Survey Quality Assurance Tool for Monitoring Urinary Catheter Bags. The monitoring will include reviewing each resident□s bag during rounding in the facility. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Compliance: 03/30/2022	

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F 690	Continued From page 81 11:30am. The Administrator stated staff should be checking catheter bag placement each time they enter Resident #77's room and that he would look for a device to keep the catheter bag off the floor when the bed was in a low position.	F 690		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 8 of 61 days reviewed (11/20/2021, 11/21/2021, 11/27/2021, 11/28/2021, 12/04/2021, 12/05/2021, 12/19/2021, and 12/25/2021). Findings included: A review of the facility's Daily Schedules for 11/1/2021 through 12/31/2021 was conducted on 02/25/2022. The Daily Schedules indicated an RN was not scheduled for at least 8 consecutive hours a day on the following dates: 11/20/2021,	F 727	F727 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	3/30/22

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F 727	Continued From page 82 11/21/2021, 11/27/2021, 11/28/2021, 12/04/2021, 12/05/2021, 12/19/2021, and 12/25/2021. On 02/25/2022 at 9:30 AM in an interview, the facility Corporate Nurse Consultant confirmed the facility had not scheduled an RN for at least 8 consecutive hours a day on 11/20/2021, 11/21/2021, 11/27/2021, 11/28/2021, 12/04/2021, 12/05/2021, 12/19/2021, and 12/25/2021. On 02/25/2022 at 10:59 AM an interview with the Administrator indicated he was aware there were days when the facility had not scheduled an RN at least 8 consecutive hours a day. He stated he had been attempting to get a waiver for this but the process had been confusing and he stopped. He stated the facility had been attempting to supplement with people from the management team and had been recruiting for RN's but there were days when the RN coverage was just not available. He went on to say there was an RN and medical provider on call 24 hours a day 7 days per week by telephone.	F 727	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to staff Registered Nurse coverage for 8 consecutive hours daily. 1. Corrective action for resident(s) affected by the alleged deficient practice: At least eight consecutive hours of registered nurse staffing will be maintained daily by 03/01/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 03/01/2022 Quality Assurance Nurse Consultant institute a two month calendar of 8 consecutive hours of RN Coverage for the entire month of March and April. This will comprise of Contracted Agency RNs until facility is able to hire additional RNs to maintain compliance. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/21/2022, the Quality Assurance Nurse Consultant educated the Staffing Coordinator on the requirement of the facility to staff Registered Nurse Coverage for 8 consecutive hours daily. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 727	Continued From page 83	F 727	requirements. The Director of Nurses will monitor compliance utilizing the F272 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks then monthly x 3 months. The Director of Nursing will monitor staffing for compliance with the requirement for at least 8 hours of registered nurse staffing daily. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/30/2022	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		3/30/22

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F 732	Continued From page 84 (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 observations, record review and staff interviews the facility failed to include the resident census on the facility posted nurse staffing for 36 of 36 days reviewed. Findings included: Observations of the facility daily nurse staff postings from 02/21/2022 through 02/25/2022 revealed the posted nurse staffing information did not include the resident census. A review of the facility nurse staffing postings from 01/21/2022 through 02/20/2022 revealed the	F 732	F732 Posted Nurse Staffing Information Based on record review, observation and staff interview, the facility failed to have an accurate staffing information posted for 36 out of 36 days reviewed. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 02/29/2022, the Staffing Coordinator were educated by the Nurse Consultant on the guidelines for daily staffing posting. On 2/29/2022 the Quality Nurse Consultant implemented the required changes to the daily staffing posting.	

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F 732	Continued From page 85 posted nurse staffing information did not include the resident census. On 02/25/2022 at 8:04 AM an interview with the Scheduler indicated she was responsible for completing and posting the facility nurse staffing. She stated when she received orientation to her position which she began in May of 2021 no one instructed her she needed to include the resident census information on the documents. On 02/25/2022 at 8:08 AM an interview with the Corporate Nurse Consultant indicated the facility policy was to include the resident census on the posted nurse staffing. She stated this information was important so anyone viewing the information could determine how many nursing staff were available to care for residents.	F 732	The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 02/29/2022, Quality Assurance Nurse Consultant completed a new staffing posting sheet in accordance with the guidelines for staffing postings. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or designee will review the daily staffing posting for accuracy. This will be done daily during the week, and the weekend sheets will be reviewed Monday. The Administrator or designee will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN assistant, Therapy Manager, Health Information Manager, Dietary Manager and Administrator attend the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 03/30/2022	

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F 755	Continued From page 86	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to obtain medications via their backup pharmacy for 1 of 5 residents reviewed	F 755	F755 The statements made on this plan of	3/30/22

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F 755	Continued From page 87 for medications. (Resident #46) Findings included: Resident #46 was admitted to the facility on 3/4/19. Her active diagnoses included atherosclerotic heart disease of native coronary artery, atrial fibrillation, other psychotic disorder not due to a substance or known physiological condition, and major depressive disorder with psychotic symptoms. Resident #46's care plan dated 12/29/21 revealed she was care planned to receive antipsychotic medication related to a diagnosis of psychosis with visual hallucinations and risk for adverse side effects. The interventions included to administer medications as ordered by the physician. Resident #46 was ordered on 10/23/19 to have Seroquel 250 milligrams by mouth at bedtime for psychosis. Resident #46's Medication Administration Record (MAR) for September 2021 revealed on 9/24/21 Nurse #11 documented Seroquel 250 milligrams by mouth was not given and to see nursing notes. On 9/25/21 and 9/26/21 Nurse #12 documented Seroquel 250 milligrams by mouth was not given and to see nursing notes. A review of Resident #46's medical records for September 24th through September 25th of 2021 revealed there were no nursing notes in reference to Seroquel not being administered. There was no documentation of attempting to contact the backup pharmacy.	F 755	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: On 09/27/21, the McNeill□s Pharmacy delivered resident #46 medication to the facility. Medical Director was notified of missed dosages of Seroquel for Resident #46 on 02/23/2022 by Unit Manager. No new orders received. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents in the facility who have physician orders have the potential to be affected. Beginning on 03/15/2022, the Quality Assurance Nurse Consultant audited 100% of all residents MARs and TARs for notifications of medications not available to the residents. This was completed on 03/15/2022. On 03/15/2022, the Director of Nurses (DON) or designee initiated daily audits (Monday □ Friday, with Monday reviewing Saturday and Sunday) of all medication	

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F 755	Continued From page 88	F 755		

Nurse #11 and Nurse #12 were unavailable for interview.

During an interview on 2/21/22 at 11:09 AM Resident #46 stated at some point in September of 2021 she did not receive her Seroquel as ordered and did not understand why.

During an interview on 2/21/22 at 11:35 AM Nurse #10 stated she thought in September sometime Resident #46 did not have Seroquel on the cart and it took a day or two to get it, but she was not involved in that issue, she just heard about it later. She did not know why it took so long for a nurse to get Resident #46's medications because the facility had a backup pharmacy they could contact 24/7 to get any missing medications as soon as possible.

During an interview on 2/22/22 at 11:11 AM the Administrator stated he was unaware of any concerns with Resident #46's Seroquel in September 2021. He further stated the facility had a backup pharmacy for nurses to contact to obtain medications not available to them. He concluded the nurses should have followed the procedure for their backup pharmacy to obtain the Seroquel for Resident #46 and he had no documentation this was done.

During an interview on 2/23/22 at 8:16 AM Physician #1 stated he could not remember if he was notified in September 2021 of Resident #46 not receiving her Seroquel and that the facility had systems to get medications for residents that were unavailable and could not speak to if the nurses followed these procedures or did not. He concluded there were no negative outcomes from Resident #46 not receiving Seroquel those three

carts for medication not available with a review of PCC to ensure all notifications if needed were completed in a timely manner.

Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education:
On 03/02/2022, the QANC and designee began reeducating all full time, part time, agency staff, and PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics (See education):
" Medication Availability from Back up Pharmacy
" Following Physician Orders
This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As 03/30/2022, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.
Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Administrator or designee will monitor compliance utilizing the Medication Audit Report Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor notification process for medications not available. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will

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F 755	Continued From page 89 days. During an interview on 2/23/22 at 10:32 AM the Corporate Nurse Consultant stated they did not have any further documentation of what happened with Resident #46's Seroquel on 9/24/21 through 9/26/21. She stated the nurses should have notified the backup pharmacy which was available 24/7 per their policy and gotten the Seroquel as soon as possible. She concluded the nurses were agency and did not follow the policy for their backup pharmacy.	F 755	be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/30/2022	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure it was free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 26 opportunities resulting in a medication error rate of 7.69% for 2 of 4 residents observed for medication administration (Resident #31 and Resident #589). Findings included: 1 a. An observation was completed on 2/24/22 at 9:40 AM of Nurse #3 who administered Aspirin Enteric Coated 81 milligrams (mg) to Resident #589.	F 759	F759- Free of Medication Rate 5 % or More The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice:	3/30/22

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F 759	Continued From page 90 A review of the physician orders for Resident #589 revealed an order dated 12/29/21 for Aspirin 325 mg Enteric Coated to be administered once a day. On 2/24/22 at 10:10 AM interview was completed with Nurse #3, and she stated she gave Aspirin 81 mgs to Resident #589. After reviewing the physician orders for Resident #589, she stated the order was for Aspirin 325 mgs and that is what should have been given to Resident #589. b. On 2/24/22 at 2:00 PM Nurse #4 was observed as she prepared and administered the medication Hydralazine 10 mg tablet (a blood pressure medication) and Prostat (a liquid protein supplement) 30 milliliters (mls) to Resident #31 via his gastrointestinal tube (G-tube). Nurse #4 crushed the Hydralazine tablet and placed it in a cup and diluted it with 15 mls of water. Nurse #4 measured out 30 mls of Prostat and added 15mls of water. Nurse #4 administered the Hydralazine first followed by the Prostat. Nurse #4 then flushed the G-tube with 30 mls of water. Nurse #4 did not administer a 30 ml flush of water before the medications were given and did not administer a 5 ml flush of water between the 2 medications. A review of physician orders revealed the following order: Every shift first flush with 30 mls of water then administer each medication separately. Dissolve each medication in 10-15 mls of water and flush with 5 mls of water after each medication. Flush with 30 mls of water as a final flush. An interview was conducted with Nurse #4 at 2/24/22 at 2:10 and she stated she knew she was	F 759	On 03/17/2022 the Quality Assurance Nurse Consultant assessed resident #589. Findings were no harm noted to resident #589. On 02/25/2022 the Resident #589 received appropriate medication per policy during medication administration. Additionally, the MD was notified of medication error 03/16/2022 Quality Assurance Nurse Consultant. On 03/17/2022 and 03/18/2022, the Quality Assurance Nurse Consultant reeducated the Nurse #3 on following physician orders and Nurse #4 on Medication administration through a G Tube, Medication Administration, and following physician orders. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 03/15/2022 the Quality Assurance Consultant and RN designees began Medication Pass Observation/ Competencies on 100% of Licensed Nurses and Med aides. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/16/2022 the Quality Assurance Nurse Consultant and RN designees began educating all full time, part time, and prn nurses, medication aides, and agency staff on the following topics: Medication administration process to assure that medications are provided to residents per medical order. Beginning 03/15/2022, medication aides and licensed nurses began re-competency by the Quality Assurance Nurse Consultant/Director of Nursing / RN	

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F 759	Continued From page 91 to flush with 30 mls of water first and give a water flush between medications but she just forgot to do it. An interview was conducted with the Administrator on 2/25/22 at 10:30 AM. He was provided the medication error rate and stated medications should have been given to the residents per physician orders.	F 759	designee on the medication administration process and med pass observations. The Director of Nursing will ensure any nurse or medication aide will not be allowed to work until training completed after 03/30/2022. The Director of Nursing will ensure that any newly hired/agency nurse or medication aide who has not completed education by 03/30/2022 will receive education on Medication Administration related to Plan of Correction during orientation and any agency nurse/medication aide utilized by the facility will receive education on Medication Administration related to Plan of Correction prior to working their shift. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 759 Med Pass QA monitoring tool. Monitoring will include observing medication pass following the 6 rights of medication administration for 1 medication aide and 1 nurse 2 x a week for 4 weeks, then monthly x 3 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/30/2022	

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F 802	Continued From page 92	F 802		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, interviews with facility staff and record review the facility failed to have sufficient staff to complete the duties assigned to the dietary department. This had the potential to affect residents receiving food from the kitchen. The findings included: This tag is cross-referenced to F 806. Based on observation, record review and interviews with residents and facility staff the facility failed to obtain food preferences for residents including newly admitted residents and failed to provide preferred food selections for residents when select menus were not incorporated into the meal	F 802	F802 Sufficient Dietary Support Personnel The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective action for affected residents.	3/30/22

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F 802	Continued From page 93 tray slip system. The facility also for 4 of 4 residents reviewed for complaints about food preferences (Residents #65, #136, #47, #17). During an observation of the kitchen on 2/21/22 at 1035 AM the Interim Dietary Manager was observed in the cooking area. He sated he was the corporate consultant for the contracted food service company and was working as the Interim Dietary Manager since 2/13/22. During an observation on 2/22/22 at 11:50 AM the Interim Dietary Manager stated he was the cook today because the scheduled cook had to leave. He added he was running behind schedule for the lunch meal. On 2/23/22 at 11:11 AM the Interim Dietary Manger was observed cooking lunch. During an interview he stated the person scheduled for the cook that day did not show up for the shift. He also said he had some agency staff working in the kitchen, but they had never worked in the facility previously, so he assigned them to work in the dish washing area. On 2/25/22 at 10:20 AM the Administrator stated he was aware the kitchen was without staff because he had received invoices from a different staffing agency than the ones used by the corporation for the facility.	F 802	Based on observations and interviews dietary services failed to meet sufficient staff requirements to provide meals on facility schedule and address 4 of 4 resident food preferences/meal selections. For resident□s #17, #65, #136, #47: Food preferences not honored or not collected. Corrective action for potentially affected residents. On 3/18/2022 the Administrator, Nurse Consultant, and Senior Nutrition Service Coordinator had a meeting with the Dietary Regional Director of Operations to discuss staffing needs and expectations for Dietary Services. External and internal job postings were posted to various hiring avenues following 3/18/2022 review. On 3/25/2022 two dietary staff were hired for aide positions. On 3/28/2022 a Dietary Service Director was hired for an interim full time position until the position could be filled permanently. On 3/30/22022, the Dietary Service Director and Administrator completed a 100% review of staffing ratios and assignments; the review revealed sufficient staffing for the facility based on current census. For residents #17 and #65 food preferences were clarified and updated in Traycard systems following Dietitian visits 3/18/2022. Residents #136 and #47 discharged prior to initiation of plan of correction. Systemic changes On 3/28/2022, the Dietary Regional Director of Operations in-serviced all full	

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F 802	Continued From page 94	F 802		

time, part time, and to agency dietary staff. Topics included:
" The importance of staff call-outs; notification to Dietary Regional Director of Operations and Administrator when unable to complete assigned shift.
" Staffing assignments and scheduling for current census.
" The Dietary Regional Director Administrator will review daily staffing schedules twice a day to ensure staff scheduled are present in the facility to meet meal service needs for current census.
" The importance of maintaining meal times and honoring food preferences; food preferences and meal selections to be added to daily rounding.
The Dietary Director of Operations will ensure that any dietary staff who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency dietary staff that provide services for the facility.
Quality Assurance
The Dietary Service Director will monitor this issue using the Dietary Quality Assurance Tool for Sufficient Staffing. The review will consist of reviewing staffing scheduling and ensuring sufficient staff are present each shift to provide

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F 802	Continued From page 95	F 802	appropriate meal services at least three times a week for 4 weeks, then weekly for 8 weeks or until resolved by the Quality of life/Quality Assurance Committee; a review of staffing schedules, staffing ratios, and assignments to include current census needs. Interventions will be implemented as appropriate. The Dietary Service Director will provide reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 3/30/2022	
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and facility staff the facility failed to obtain food preferences for	F 806	F806 The statements made on this plan of correction are not an admission to and do	3/30/22

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residents including newly admitted residents and failed to provide preferred food selections for residents when select menus were not incorporated into the meal tray slip system. This was for 4 of 4 residents reviewed for complaints about food preferences (Residents #65, #136, #47, #17).

The findings included:

A. Resident #17 was admitted to the facility on 3/3/20 with diagnoses which included chronic obstructive lung disease and diabetes.

A review of the quarterly minimum data set dated 10/26/21 revealed Resident #17 was cognitively intact.

On 2/22/22 at 8:48 AM Resident #17 stated she could not eat the turkey sausage because she did not like it. She added she had asked the dietary department for the last month to give her bacon instead of sausage, but it had not changed.

B. Resident #65 was admitted to the facility on 9/22/21 with diagnoses which included chronic kidney disease, heart failure and peripheral vascular disease.

A review of the significant change minimum data set dated 12/27/21 revealed Resident #65 was cognitively intact.

A review of the diet orders revealed he was ordered a cardiac regular diet.

During an interview with Resident #65 on 2/25/22 at 10:14 AM he stated he frequently received foods he did not want to eat including Mexican

not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
1. Corrective action
Based on meal observations and interviews between 02/22/2022 and 02/25/2022 the facility failed to obtain food preferences and provide preferred food selections for 4 of 4 residents. It was observed at more than one meal resident #17 was served turkey sausage instead of bacon after asking the dietary department for the last month that she could not eat sausage because she did not like it. During observation, resident #136 stated she was not going to select any foods on the select menu because she claimed you never get what you want. It was noted during observation on 02/22/22 resident #47 was completing her select menu as well as she could since she didn□t have a pen or pencil to write with though she was not receiving the selections she chose on the select menu. It was also noted during observation on 02/25/2022 resident #65 received foods he did not want to eat like Mexican food and that no one from dietary has visited him to discuss preferences.
On 3/18/22, dietitian visited resident #65, food preferences updated. Resident #65 added to menu selection program and salt substitute added to trays. Dietitian visited

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F 806	Continued From page 97 style foods. Resident #65 said no one from dietary had visited to discuss his preferences. He said he did not know anything about a select menu. C. Resident #136 was admitted to the facility on 2/7/22 with diagnoses which included multiple fractures of the pelvis, rheumatoid arthritis, chronic kidney disease, and gastro-esophageal reflux disease. A review of the admission MDS dated 2/13/22 revealed Resident #136 was cognitively intact. On 2/22/21 at 8:27 AM she was observed with a piece of paper in her hand. She stated the paper was the select menu for the following day. She said she was not going to select any foods for tomorrow because "You never get what you want." D. Resident #47 was admitted to the facility on 2/10/22 with diagnoses which included hip fracture and arthritis. The admission minimum data set dated 2/16/22 revealed Resident #47 was cognitively intact. On 2/22/22 at 5:11 PM Resident #47 stated she completed her select menu as well as she could since she did not have a pen or pencil to write with. She stated she would just leave the select menu on her tray, but she had not previously received the selections she chose. During an interview with the Interim Dietary Manager on 2/22/22 at 12:25 PM he stated the select menu options were sent on the breakfast tray to all residents who were getting regular	F 806	resident #17 on 3/18/22, food preferences obtained. Resident #17 said she does not want to be added to menu selection program. Residents #136 and #47 discharged from facility prior to plan of correction. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff in-serviced 3/28/2022 regarding accuracy of meals served and diet consistency policies. All dietary staff are to have competencies evaluated. All current entries in Traycard will be reviewed for accuracy and modified as needed by 3/28/2022. Menu selection program modified to ensure all residents cognitively appropriate receive menu selections and are assisted as needed with program. Ambassador program to add food preferences to daily rounds. All residents will be interviewed to update food preferences by 3/30/2022. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director on 3/28/2022. Topics included: ¿ Tray Accuracy Education ¿ Diet Consistency and Accuracy Policies ¿ Meal Service Policies ¿ Meal Selection Program Process This information has been integrated into the standard orientation training and in the	

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consistency foods. He said only 10-12 of the residents' select menus were returned to be processed by the dietary department although they usually served 72 regular consistency diets. The Interim Dietary Manager stated he was assigned to complete the food preferences for all newly admitted residents. He reported food preferences were to be completed within 72 hours of admission, but he had not visited residents because he was working as the cook most days, so he was not able to fulfill all the Dietary Manager duties.

On 2/22/22 at 3:45 PM the Interim Dietary Manager said he realized the select menu process was not very successful. He said he was not aware of Resident #17's preference for bacon instead of sausage.

On 2/23/22 at 3:47 PM the Interim Dietary Manager stated the Dietary Manager usually obtained food preferences on admission and then periodically afterwards. He added when the preferences are obtained, they would be put into the computerized menu tray slip system so the preferences would print out on the tray slip. The tray slip was used by the dietary aides during meal service to put correct selections onto the plate.

On 2/23/22 at 12:28 PM the Registered Dietitian stated the Dietary Manager was responsible to visit residents to obtain food preferences. She stated there was a daily alternate menu and a choice menu was used for some residents. She said the Dietary Manager obtained food preferences after each minimum data set assessment or more frequently if needed for residents with food complaints or if the resident

required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

Traycard to be reviewed and modified on admissions, quarterly, and as needed by Dietary Service Director.

Menus to be reviewed daily and modified per diet preferences as needed by Dietary Service Director.

4. Quality Assurance monitoring procedure.
The Dietary Services Director will monitor accuracy of completed trays served to residents per Dietary Meal QA Audit weekly x4 and then monthly x 2. Traycard will be audited monthly and test trays completed monthly per policy by the Dietary Service Director. The consultant dietitian will complete quarterly diet orders. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by the Ambassador Program daily and reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director.

Date of compliance: 3/30/2022

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F 806	Continued From page 99 requested a visit. The Registered Dietitian then said food preferences should be obtained within 48 hours of admission or 72 hours if admitted late on a Friday. 02/25/22 10:20 AM the Administrator stated they tried to correct the select menu process this week by putting baskets out for the staff to place the select menus in.	F 806		
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, record review and interviews with facility staff the facility failed to label opened food items stored in refrigerators with an open date or a use by date for 1 of 1 walk-in cooler and 1 of 2 nourishment room	F 812	F812 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	3/30/22

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F 812	Continued From page 100 refrigerators. The facility also failed to maintain the refrigerator in the 400 hall nourishment room free from dried food buildup and dried spills for 1 of 2 nourishment room refrigerators. This practice had the potential to affect foods served to residents. The findings included: 1. On 2/21/22 at 10:40 AM an observation of the walk-in refrigerator was conducted with the Interim Dietary Manager. The observation revealed a package of left over wild rice and a package of taco sauce. No label was present on those items. During an interview with the Interim Dietary Manager on 2/21/22 at 10:45 AM he stated the food items did not contain a label so he would discard them. 2. On 2/22/22 at 3:30 PM an observation of the 400 Hall nourishment room refrigerator revealed there was dried applesauce in the compartment on the door. There were spots of various colors of dried liquid on the bottom interior of the nourishment refrigerator. There was a single serve container of applesauce in the door compartment, which was partially open with no covering, so the applesauce was exposed. Observed on the top shelf was a single serve container of vanilla pudding which was opened. It was not dated or covered to seal the contents. On the second shelf In the back of the refrigerator was a black disposable bowl with a clear lid which contained spaghetti. The container had no label on it. On 2/22/22 at 3:30 PM the Interim Dietary	F 812	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. For dietary services, a corrective action was obtained on 2/21/2022 and 2/22/2022. During initial walk through of the kitchen on 2/21/2022, it was noted dietary services had failed to label and date left over packages of wild rice and taco sauce. The Interim Dietary Service Director discarded the unlabeled wild rice and taco sauce. During observation of the 400 Hall nourishment room on 2/22/2022 the fridge was noted to have dried applesauce on the door and multiple areas of dried liquids on the bottom interior. It was also noted that staff failed to properly store multiple items: an opened single serve applesauce, open single serve vanilla pudding, and a unlabeled disposable bowl for spaghetti. The Interim Dietary Service Director discarded the pudding, applesauce, and spaghetti; and Environmental Services cleaned the fridge. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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	345519	A. BUILDING _____ B. WING _____	C 02/25/2022

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F 812	Continued From page 101 Manager stated the single serve applesauce and pudding should have been discarded and not placed in the refrigerator. He added the bowel of spaghetti should have a label on it and because there was no label it should be thrown away. The Interim Dietary Manager stated the dietary staff stock the nourishment refrigerator but were not responsible for cleaning the refrigerator. He said the housekeeping staff were responsible for cleaning the nourishment refrigerator. During an interview with the Administrator on 2/25/22 at 10:20 AM he stated opened food items stored in any of the facility refrigerators should be labeled and dated correctly. He said foods should be stored to prevent possible contamination. He added the nourishment refrigerators should be kept clean.	F 812	All residents have the potential to be affected by the alleged deficient practice. On 2/21/2021, the Interim Dietary Service Director completed a kitchen walk through to ensure all food items were within their dates and dated properly. On 2/22/2021 the Interim Dietary Manager visited all nourishment rooms to ensure all items in nourishment fridge and surrounding areas were labeled, dated, and stored properly. On 2/23/2021 environmental services staff cleaned all nourishment fridges. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 3/28/2022 by Dietary Service Director. Topics included: " Storage and dating policies and regulations. " Shift inspections to observe all food are within their dates and tossed if out of date. " Shift inspections to observe nourishment room items are with their dates and/or stored properly. " Policies and practices for nourishment room scheduled cleaning. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Dietary staff will monitor proper food	

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F 812	Continued From page 102	F 812	storage in the nourishment room while restocking nourishment rooms on AM and PM shifts. Environmental staff will monitor nourishment room cleanliness by cleaning per daily checklist. 4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of compliance: 3/30/2022	
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	F 842		3/30/22

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F 842	Continued From page 103	F 842		

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 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.

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F 842	Continued From page 104 §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. §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 observation, record review, and staff interviews the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 5 residents (Resident #10) reviewed for activities of daily living. Findings included: Resident #10 was admitted to the facility on 5/4/21. Resident #10's minimum data set assessment dated 10/31/21 revealed she was assessed as severely cognitively impaired. Transferring activity only occurred once or twice during the lookback period. She was totally dependent on staff for	F 842	F842 (Resident Records □ Following Resident MAR) The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Affected Residents On 02/22/2022 Resident #10□s Physician	

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F 842	Continued From page 105 dressing, eating, toilet use, and personal hygiene. Resident #10 was ordered on 1/11/22 to get out of bed every other day for a few hours and be placed in the TV room. Resident #10's MAR for February 2022 revealed she was documented to have gotten out of bed by Nurse #10 on the 2/2/22, 2/8/22, 2/12/22, 2/16/22, and 2/22/22. During observation on 2/22/22 at 9:05 AM, 11:27 AM, 1:05 PM, 2:31 PM, and 3:30 PM Resident #10 was observed to be in bed. During an interview on 2/22/22 at 3:38 PM Nurse #10 stated Resident #10 did not get out of bed those days she had checked the MAR as the order being complete. She stated she needed to review that order as it had not been followed those days. She reported this was because she had not paid attention to that order and just checked it as complete. She concluded the order would need to be clarified and she had not noticed that order until it was brought to her attention now. During an interview on 2/22/22 at 3:52 PM the Corporate Nurse Consultant stated Nurse #10 should not have signed off something as completed when it was not done as it was an inaccurate medical record. She further stated physician orders where to be followed or clarified if there were any concerns and this should have been done.	F 842	was notified by Nurse #10 safety concern regarding positioning and poor trunk control. Order given to hold get out of bed order until Therapy can evaluate for additional adaptive equipment needed. On 03/10/2022, therapy ordered a lateral support. Lateral support was initiated to resident□s geri chair on 03/17/2022. Physician notified of new modifications to geri chair on 03/17/2022. New order received to assist resident out of bed every other day. On 02/22/2022, Nurse #10 was immediately educated by Quality Assurance Nurse Consultant on following Physician orders and documenting accurately in the medical record. Corrective Action for Potentially Affected Residents All residents that have orders to get out of bed have the potential to be affected by this alleged deficient practice. On 03/17/2022, Unit Manager audit all resident records for orders to get out of bed. This was completed on 03/17/2022. Systemic Changes On 03/02/2022 the Quality Assurance and designee began in-servicing all Licensed Nurses and Med Aides. This in-service included the following topic: " Following Physician Orders The Director of Nursing will ensure that any Licensed Nurse or Medication Aide who has not received this training by 03/30/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and Medication Aide. Quality Assurance	

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F 842	Continued From page 106	F 842	The DON or RN Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring Resident with orders to get out of bed. The monitoring will include reviewing the MAR and observing resident to ensure order is followed. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Completion: 03/30/2022	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in	F 849		3/30/22

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paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

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F 849	Continued From page 108 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F 849		

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F 849	Continued From page 109 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice	F 849		

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F 849	Continued From page 110 personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews the facility failed to provide an order for hospice care for 2 of 2 residents reviewed for hospice (Resident #585 and Resident #65). Findings included: 1. Resident #585 was admitted to the facility on 12/8/21 with a re-admission on 2/7/22 with diagnoses that included Alzheimer's Disease. The admission Minimum Data Set (MDS) dated 12/15/21 revealed Resident #585 had severe cognitive impairment and required assistance with all activities of daily living.	F 849	F849 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective Action for Affected Residents For resident # 585 Physician contacted by	

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F 849	Continued From page 111 An order was reviewed by Resident #585's physician (Physician #1) dated 2/7/22 and it stated to admit resident to skilled level of care for COVID-19 with pneumonia, dementia, hypoxia, acute renal failure, and dysphagia. There was no order by the physician to admit the resident to hospice care. A hospice progress note dated 2/7/22 was reviewed and indicated Resident #585 was admitted to the facility under hospice care. On 2/22/22 at 5:00 PM an interview was conducted with Nurse #2 who admitted Resident #585 on 2/7/22. Nurse #2 stated the hospice nurse was with Resident #585 when he arrived at the facility and she asked if he was on hospice care and the hospice nurse responded yes. An interview was conducted with Physician #1 on 2/23/22 at 4:00 PM, and he stated he was unaware an order for hospice care was not placed. He stated he expected an order to be placed for hospice care if the resident was admitted to the facility with hospice care. On 2/24/22 at 1:30 PM an interview was conducted with the corporate nurse consultant, and she stated if a resident is on hospice the resident should have had an order for hospice. 2. Resident #65 was admitted to the facility on 9-22-21 with multiple diagnoses that included stage 3 chronic kidney disease, congestive heart failure and peripheral vascular disease. The significant change Minimum Data Set (MDS) dated 12-27-21 revealed Resident #65 was cognitively intact and coded for hospice services.	F 849	Unit Manager on 02/24/2022 and new order was received for Admit to Hospice Services. For resident #65 Physician was contacted by Unit Manager on 02/24/2022 and a new order was received for Admit to Hospice Services. Corrective Action for Potentially Affected Residents All Hospice residents have the potential to be affected by this alleged deficient practice. On 02/24/2022, the Unit Manager audited all Hospice residents to ensure facility had obtained Physician orders. This was completed on 02/24/2022. Systemic Changes On 03/17/2022 the Quality Assurance Nurse Consultant and designee began in-servicing with current Licensed Nursing. This in-service included the following topics: " Importance of Ensuring All Hospice resident receive a Physician order to admit to hospice. The Director of Nursing will ensure that any Licensed Nurse who has not received this training by 03/30/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring Hospice Physician	

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F 849	Continued From page 112 Review of Resident #65's Physicians orders from 9-22-21 to 2-23-22 revealed no order for hospice services. On 2-24-22 at 1:30pm the Corporate Nurse Consultant was interviewed. The Nurse Consultant confirmed Resident #65 was on hospice services and there was no order in the Physician's orders for hospice services. She stated any time a resident is placed on hospice there should be an order in the Physician's orders for hospice services. The facility's Medical Director was interviewed by telephone on 2-24-22 at 2:48pm. The Medical Director stated orders for hospice should be placed in the Physician orders. The Administrator was interviewed on 2-25-22 at 11:30am. The Administrator discussed not having a clear process on entering hospice orders. He explained many times the order was given verbally and not placed in the electronic record as an order. The Administrator stated the facility needed a tighter process from verbal to written orders in the electronic record.	F 849	Orders. The monitoring will include reviewing PCC for Hospice Consults and Admit to Hospice orders. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of Compliance: 03/30/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/30/22

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F 880	Continued From page 113 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 114 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed 1) to follow facility policy when collecting COVID-19 nasopharyngeal specimens while within six feet of residents when Phlebotomist #1 performed nasopharyngeal COVID-19 testing for 2 of 2 residents (Resident #335 and #535) and 2) failed to use a N95 mask when NA #3 entered a COVID-19 positive resident's room (Resident #336) to obtain a blood pressure reading for 1 of 1 resident. The findings included: 1. A review of the facility's COVID-19 testing policy, ID# 10994697, under the section, "Conducting testing" last revised 01/2022, revealed staff must wear full Personal Protcetion Equipment (PPE ((gloves, gowns, eye protection and N95 mask)) when collecting or processing specimens.	F 880	F880 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #335 was not affected by the alleged deficient practice. On 02/21/2022,	

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F 880	Continued From page 115 A review of Phlebotomist #1's training record revealed she was educated by the facility's staff development Nurse on "Employee COVID Specimen Collector Competency" on 01/31/2022. A review of the above stated competency revealed education topics included the required PPE for COVID testing were to wear a mask, goggles and/or face shield, a gown and gloves. An observation of COVID-19 testing on 02/21/2022 at 2:03 pm revealed Phlebotomist #1 did not wear an isolation gown (PPE) when performing nasopharyngeal swab testing for Residents #535 and #335. Phlebotomist #1 wore gloves, goggles and a KN95 covered with a surgical mask. An interview with Phlebotomist #1 on 02/21/2022 at 2:10 pm revealed she didn't wear gowns when testing residents because it would require her to use so many gowns (PPE). An interview with the Nurse Consultant and acting Infection Preventionist on 02/21/2022 at 2:34 pm revealed Phlebotomist #1 should have worn appropriate PPE when testing, which included an isolation gown, gloves, goggles and/or face shield and mask while testing. She also stated Phlebotomist #1 had been educated and trained by the facility to conduct nasopharyngeal specimen collection. 2. Record review revealed Resident #336 tested positive for COVID-19 on 02/21/2022. An observation on 02/22/2022 at 4:06 pm revealed NA #3 entered the room of Resident #336 without wearing a N95 mask to obtain a	F 880	the Quality Assurance Nurse Consultant re-educated Phlebotomist #1 on the facility policy related to wearing the required PPE including mask, goggles and/or face shield, a gown, and gloves when collecting COVID-19 nasopharyngeal specimens. Resident #535 was not affected by the alleged deficient practice. On 02/21/2022, the Quality Assurance Nurse Consultant re-educated Phlebotomist #1 on the facility policy related to wearing the required PPE including mask, goggles and/or face shield, a gown, and gloves when collecting COVID-19 nasopharyngeal specimens. Resident #336 was not affected by the alleged deficient practice. On 02/22/2022, the Quality Assurance Nurse Consultant re-educated NA #3 on the facility policy related to use of appropriate PPE including a N95 mask when entering a COVID-19 positive resident□s room. The Quality Assurance Nurse Consultant notified the Medical Director of the alleged deficient practice and of the steps taken to correct the alleged deficient practice on 03/17/2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 03/01/2022 Quality Assurance Nurse Consultant began a random audit of resident care areas to observe staff	

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F 880	Continued From page 116 blood pressure reading. This observation also revealed the PPE storage hanging on the outside of door did not have N95 masks and the posted signage on Resident #336's door read in part "Special Droplet Contact Precautions," "wear a N95 respirator or higher while providing care." NA # 3 had on gloves, KN95 mask and googles. An observation on 02/24/2022 at 10:15 am of the Central Supply stock room, revealed the following masks were available: HDX N95 Respirator Mask--small 12 boxes of 30 count. 3M--Aura1870 NIOSH N95--15 boxes of 20 count. An interview with NA #3 on 02/22/22 04:15 pm revealed her assignment included Resident #336 who had tested positive for COVID-19 on 02/21/2022. NA #3 added she did not change her mask before providing care to Resident #336 because she didn't have any N95 masks and she just uses one KN95 mask throughout her shift. An interview on 02/24/2022 at 10:15 am with the Central Supply Manager revealed she had not experienced a shortage of PPE supplies or backordered items. An interview with the Nurse Consultant and acting Infection Preventionist on 02/22/2022 at 4:24 pm revealed the facility was not short in PPE supplies and NA #3 should have worn a N95 mask when entering Resident #336's room. An additional interview with the Nurse Consultant and acting Infection Preventionist on 02/24/2022 at 2:09 PM revealed the N95 masks all required fit testing and that was the reason the facility	F 880	compliance with use of appropriate PPE including a N95 mask when entering a COVID-19 positive resident□s room. Results revealed 100% compliance. On 02/22/2022, the Quality Assurance Nurse Consultant completed observations of Phlebotomist #1 to ensure that COVID testing was performed utilizing the required PPE when collecting COVID-19 nasopharyngeal specimens. This was completed on 02/22/2022. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 03/22/2022, the Quality Assurance Nurse Consultant who has completed a course in Infection Control via NC SPICE initiated education for all facility staff, full time, part time, PRN staff, and agency staff on Infection Control and wearing PPE. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 03/30/2022, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Root Cause Analysis:	

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F 880	Continued From page 117 didn't have them available for staff to use when providing care to a COVID positive resident.	F 880	A Root Cause Analysis was initiated on 03/21/2022 to discuss the root cause analysis of this event. The team members participating in the Root Cause Analysis included the following staff members: Administrator, DON, Unit Support Nurse, Quality Assurance Nurse Consultant, Licensed Practical Nurse, Certified Nursing Assistant, and the Medical Director via telephone. A root cause analysis meeting was held to discuss ongoing solutions to address the root cause. IDT Team met during Daily QA on 03/21/2022 to discuss RCA of 2022 annual survey staff were observed not wearing a gown while performing a COVID Test and not putting on an N95 when entering a COVID Positive room. Both employees did not realize the importance of wearing PPE each and every time. Staff education provided immediately on 2/22/22 and has continued thereafter. Staff have watched the required PPE Video to ensure compliance. The infection control committee will meet weekly to discuss ongoing monitoring of PPE Compliance. All new staff will watch PPE Videos during orientation and educated to wear the appropriate PPE. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:	

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F 880	Continued From page 118	F 880	The Director of Nursing or designee will monitor compliance utilizing the F880 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with wearing appropriate PPE (to include donning/doffing of PPE) and hand hygiene practices. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager. Attestation Statement I attest that I I have completed a course in Infection Control. I am an Infection Control Preventionist having completed a course on Infection Control from NC Spice. I have provided education on PPE Use as described in the Plan of Correction for F880 at Liberty Benson Health and Rehabilitation Center between the dates of 02/22/2022-03/30/2022. Topics included: -required PPE during COVID testing -required PPE when entering a COVID-19 positive resident's room Education sessions were completed by each staff member utilizing the PPE Education. Inservice dates and times include: Feb 22, 2022 3pm-330pm	

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F 880	Continued From page 119	F 880	March 2, 2022 10:00am-10:30am March 8, 2022 2:00pm-2:30pm March 16, 2022 10:00am-10:30am As of March 30, 2022 at 5pm, any employee who has not received this education will not be allowed to work until the training has been completed. This includes all facility staff, Licensed nurses (RN's and LPN's) and Certified Nursing Assistants full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. Printed Name: Onjaleka White, RN Signature: Onjaleka White, RN, BSN Credentials: Registered Nurse, BSN Quality Assurance Nurse Consultant Date: 03/21/2022	