STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	903 W MAIN STREET YADKINVILLE, NC 27055

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E 000	Initial Comments An unannounced recertification survey was conducted on 3/14/22 to 3/17/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# CP6S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/14/22-3/17/22. Event ID # CP6S11 The following intakes were investigated: NC00184543 and NC00181964. 2 of the 8 complaint allegations were substantiated, resulting in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		4/4/22

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

Electronically Signed | 04/01/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a dignified dining experience by standing while providing assistance with feeding for 1 of 4 residents (Resident #72) reviewed for assistance with dining, and failed to provide a cover for a catheter drainage bag for 1 of 3 residents (Resident #92) reviewed for catheters. Findings included: 1. Resident #72 was admitted to the facility on 3/22/21 with diagnoses that included, in part, dementia, abnormal weight loss and dysphagia. The annual Minimum Data Set (MDS) assessment dated 1/22/22 revealed Resident #72	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights/Exercise of Rights Corrective Action for Affected Residents 1. For resident # 72, a corrective action was obtained on 3/14/2022. The Director of Nursing immediately reeducated Unit	

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F 550	Continued From page 2	F 550		

had impaired memory and severely impaired daily decision making skills. She required extensive assistance with eating.
The care plan, updated 2/28/22, revealed focused areas of activities of daily living and weight loss. An intervention included, "Requires total assistance to eat."

On 3/14/22 at 12:55 PM, Resident #72 was observed in her bed. Unit Manager #1 entered the room with a meal tray and placed the resident in an upright seated position. She placed the meal tray on the overbed table next to Resident #72's bed. Unit Manager #1 stood while she fed the resident and remained above eye level of Resident #72 for the duration of the meal. Unit Manager #1 exited Resident #72's room at 1:09 PM after Nurse Aide (NA) #5 entered the room and assisted the resident with finishing the lunch meal.

An interview was completed with Unit Manager #1 on 3/14/22 at 1:10 PM, during which she stated Resident #72 had to be fed her meal. She said she typically stood up when she fed residents, including Resident #72. Unit Manager #1 thought the facility discussed in the "feeding class" whether staff were to be seated or stand when they fed a resident.

NA #5 was observed on 3/14/22 at 1:12 PM as she fed Resident #72. She stood up next to Resident #72 while she fed her and remained above eye level of the resident for the remainder of the meal. At 1:21 PM, NA #5 removed the lunch tray from the resident's room. In an interview with NA #5 on 3/14/22 at 1:22 PM, she explained she stood while she fed Resident #72 since she had filled in for Unit Manager #1, who

Manager #1 and Nurse aide (NA)#5 on the resident's right to dignity, respect and feeding residents while sitting and at eye level. On 3/14/2022, the Director of Nursing monitored halls during dinner to ensure no staff standing while feeding residents. No further issues noted.
2. For resident# 92, a corrective action was obtained on 3/15/2022. Nurse #5 changed drainage bag with privacy cover. On 3/15/2022, the DON educated Nurse#5 and NA#3 related to maintaining resident dignity and respect related to privacy cover for catheter bag.

Corrective Action for Potentially Affected Residents
1. All residents who need assistance with meals have the potential to be affected by this alleged deficient practice. On 3/24/2022, the Administrator and Director of Nursing (DON) identified all residents that require assistance with feeding. The Assistant Housekeeping Supervisor assessed the rooms to ensure that there was adequate seating for staff members to sit while feeding.
2. All residents with a catheter have the potential to be affected by the alleged deficient practice. On 3/22/2022, the Infection Control RN identified all current residents in the facility with an indwelling catheter and ensured those 5 resident□s catheter drainage bags had a privacy cover in place.

Systemic Changes
On 3/22/2022, the Administrator began

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F 550	Continued From page 3 had left the room. NA #5 shared that typically she sat when she fed a resident. During an interview with the Director of Nursing on 3/17/22 at 1:20 PM, she said staff were educated to be seated and at eye level when they fed a resident to promote dignity. She explained the facility monitored staff and made sure they were seated when the fed a resident and added the facility had completed inservices with staff in the past regarding dignity when feeding a resident. 2. Resident #92 was admitted to the facility on 2/8/2022 with diagnoses to include sacral pressure ulcer and depression. An admission Minimum Data Set assessment dated 2/15/2022 revealed Resident #92 had moderately impaired cognition and had an indwelling catheter. On 3/14/2022 at 10:28 AM, Resident #92 ' s urinary drainage bag, containing urine, was observed from the hall. The bag was positioned on the door side of the bed, off the floor and without a privacy cover in place. On 3/15/2022 at 10:10 AM, Resident #92 ' s urinary drainage bag, containing urine, was observed from the hall. The bag was positioned on the door side of the bed, off the floor and without a privacy cover in place. On 3/15/2022 at 10:11 AM, an interview was conducted with Nursing Assistant (NA) #3. She stated she saw Resident #92 did not have a privacy cover for his urinary drainage bag and told the nurse.	F 550	in-servicing all current full time, part time and PRN staff. This in-service included the following topics: " Proper positioning for assisting resident with meals to maintain dignity of resident " Ensuring catheter bags are cover with privacy cover to protect privacy and maintain dignity of resident The Administrator will ensure that any staff, including new hires and agency staff, who has not received this training by 4/4/2022, 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 Nurses and NA□s who give residents care in the facility. Quality Assurance 1. Beginning the week of 4/5/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Dignity (Feeding). The monitoring will include reviewing a sample of residents prior to and during meal time to ensure dignity is maintained while feeding residents. This will be completed 5 x weekly for 2 weeks then weekly times 3 months or until resolved to ensure their needs are met.	

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F 550	Continued From page 4 On 3/15/2022 at 10:20 AM, Nurse #5 was interviewed. She stated the night shift was going to change Resident #92 ' s catheter drainage bag because it looked like it was dirty, but they could not find the right bag. Nurse #5 stated she would have to check with the supply clerk. Nurse #5 then asked NA #3 to look in the supply closet located across from the nurse ' s station and NA #3 returned with a drainage bag with a privacy cover. On 3/17/2022 at 3:20 PM, the Director of Nursing was interviewed. She stated urinary drainage bags with privacy covers were in the supply closet and Resident #92 should have had one in place.	F 550	2. Beginning the week of 4/5/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Dignity (Catheters). The monitoring will include reviewing all residents with an indwelling urinary catheter to ensure privacy and dignity are maintained for residents with catheters. This will be completed 5 x weekly for 2 weeks then weekly times 3 months or until resolved to ensure their needs are met. Reports will be given by the Director of Nursing 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, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		4/4/22

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F 583	Continued From page 5	F 583		

residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to protect residents' private health information by leaving confidential medical information unattended and exposed on a medication cart computer in an area accessible to others for 1 of 4 medication carts observed.

Findings included:

On 3/14/22 at 11:25 AM an observation of the 400 hall revealed the medication cart was left unattended by staff. The medication cart computer was opened and exposed ten resident names and room numbers. Nurse #1 was observed going in a supply room and was out of sight of the medication cart computer for four minutes.

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.
F583 Personal Privacy/Confidentiality of Records
Corrective action for resident(s) affected by the alleged deficient practice:
On 3/14/2022, the Director of Nursing

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F 583	Continued From page 6 An interview with Nurse #1 at 11:35 AM revealed she knew the residents' medical information was to be protected but stated she was nervous and had forgotten to lock or hide the computer screen before she walked away from the medication cart. In an interview with the Administrator on 3/17/22 at 9:48 AM, she shared that she immediately spoke with Nurse #1 after the incident and stated that all nurses and med techs were aware that when they stepped away from a medication cart the computer screen should be locked or hidden. The Administrator added they were in the process of completing an in-service reminding staff the importance of keeping the residents' personal information private.	F 583	reeducated Nurse #1 related to protecting resident health information at all times and that computer screens should have privacy button clicked or laptop closed prior to walking away from screen. Corrective action for residents with the potential to be affected by the deficient practice: All residents have potential to be affected by the deficient practice. On 3/22/2022, the Administrator completed an audit by rounding throughout the facility to observe for potential issues related to leaving confidential medical information unattended. No privacy /confidentially issues noted during rounds. Systemic Changes: On 3/22/2022, the Administrator began educating all licensed nurses and medication aides related to resident privacy and the right to secure and confidential personal and medical records. The Administrator will ensure that any staff including new hires and agency staff who has not received this training by 4/4/2022, 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 Nurses and medication aides who utilize EMAR in the facility. Quality Assurance	

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F 583	Continued From page 7	F 583	Beginning the week of 4/5/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Confidentiality of Records. The monitoring will include observing medication carts on halls to ensure resident personal and medical record is protected. This will be completed 5 x weekly for 2 weeks then weekly times 3 months or until resolved to ensure the resident personal and medical record is protected. Reports will be given by the Director of Nursing 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, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
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: Based on staff interviews and record review, the facility failed to accurately code the medications received section (Section N) on the Minimum Data Set (MDS) assessment for 1 of 5 residents (Resident #38) reviewed for unnecessary medications.	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	4/4/22

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F 641	Continued From page 8 Findings included: Resident #38 was admitted to the facility on 7/2/21 with diagnoses that included, in part, coronary artery disease and congestive heart failure. The physician orders were reviewed and revealed an order dated 11/19/21 for Demadex (a diuretic medication), 40 milligrams, daily. The January 2022 Medication Administration Record (MAR) indicated Resident #38 received Demadex daily. The quarterly MDS assessment dated 1/9/22 revealed Resident #38 received a diuretic medication zero of seven days during the look back period. On 3/17/22 at 11:01 AM, an interview was completed with MDS Nurse #1. She said when she coded medications on section N of the MDS they were coded per drug classification and not how they were used. She reviewed the quarterly MDS assessment for Resident #38 and said there was a part time MDS Nurse (MDS Nurse #2) who completed the assessment for Resident #38. MDS Nurse #1 verified the resident received Demadex every day during the lookback period. She stated Demadex was a diuretic and should have been coded as such on the MDS assessment. She thought MDS Nurse #2 may have overlooked the medication when she completed the assessment. An attempt to interview MDS Nurse #2 by telephone was unsuccessful.	F 641	Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 38: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [1/9/2022] was modified 3/18/2022. Identification of other residents who may be involved with this practice: All current residents who have received antidiuretic medication during the Minimum Data Set (MDS) 7 day look back for assessment reference date(s) have the potential to be affected by the alleged practice. On 3/29/2022 through 3/31/2022 an audit was completed by the Director of Nursing to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have had antidiuretic medication during the Minimum Data Set (MDS) 7 day look back for assessments reference dates were coded correctly. No further resident Minimum Data Set Assessments were modified and 73 Minimum Data Set Assessments were already coded accurately. This was completed on 3/31/2022. Systemic Changes: On 3/31/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and Minimum Data Set (MDS) Support nurse and any other Interdisciplinary team	

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F 641	Continued From page 9 During an interview with the Director of Nursing on 3/17/22 at 1:18 PM, she said she was unsure if anyone in the facility routinely audited MDS assessments for accuracy. She added the corporate office provided education and support to the MDS staff related to MDS assessment accuracy.	F 641	member that participates in the MDS assessment process were in-serviced/educated by the Director of Nursing. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section N:0410 Medications Received. Indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7days or since admission/entry if less than 7days. Enter 0: if medication was not received during the last 7days; antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, Diuretic and Opioid. Review the resident□s medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). This in service was completed by 3/31/2022. Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the Minimum Data Set assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the	

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F 641	Continued From page 10	F 641	standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, beginning the week of 4/5/2022, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that Section N: 0410 Medications Received is coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		4/4/22

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the 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

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F 655	Continued From page 12 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 record review and staff interview, the facility failed to develop a baseline care plan to address the immediate needs of a resident at risk for falls for 1 of 8 residents reviewed for accidents (Resident #92). Resident #92 was admitted to the facility on 2/8/2022 with diagnoses to include sacral pressure ulcer and depression. A Nursing Admission Review dated 2/8/2022 indicated a risk alert for falls. An admission Minimum Data Set assessment dated 2/15/2022 revealed Resident #92 had moderately impaired cognition and was non-ambulatory. He required extensive assistance with 1-2 people for bed mobility and transfers. Resident #92 had an indwelling catheter and was incontinent of bowel. A review of the Care Area Assessment (CAA) revealed falls would be care planned due to antidepressant and antipsychotic drug use. A review of the care plan dated 2/9/2022 revealed no focus area for risk for falls. A focus area of alteration in hematologic status included an intervention to complete fall risk assessment and increase vigilance for falls. A comprehensive medical record review revealed a fall risk assessment was not completed.	F 655	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. F655 Baseline Care Plan Corrective Action: On 3/17/2022, the Director of Nursing completed Resident # 92 Baseline Care Plan to include actual fall and further risk for falls. Identification of other residents who may be involved with this practice: All current residents who are new admissions and at risk for falls have the potential to be affected by the alleged practice. On 3/29/2022 through 3/31/2022 an audit was completed by the Director of Nursing to review all new admissions in the last month (March 1st 2022 to March 31st 2022) and ensure that a base line care plan for those at risk for falls was developed within 48 hours of admission to the facility. All 16 new admissions who are at risk for falls have a completed baseline care plan. This was completed on	

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F 655	Continued From page 13 A nurse ' s note dated 3/10/2022 revealed Resident #92 ' s wife awoke to find Resident #92 on the floor. No injuries were noted. Resident #92 was very restless this shift and had not slept. On 3/14/2022 at 2:30 PM, Resident #92 was observed lying in bed. Resident #92 ' s family member was sitting in the recliner in Resident #92 ' s room and stated her and another family member were sleeping in the facility every night because Resident #92 tried to get out of bed on his own. On 3/17/2022 at 3:20 PM an interview was conducted with the Director of Nursing. She stated risk for falls should have been included in Resident #92 ' s baseline care plan.	F 655	03/31/2022. Systemic Changes: On 03/31/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and Minimum Data Set Support nurse and any other Interdisciplinary team member that participates in the Base line Care plan process were in-serviced /educated by the Director of Nursing. The education focused on: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-(i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of the resident's admission. 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	

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the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.

This in service was completed by 03/31/2022. Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the Baseline Care plan process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.
Monitoring:
To ensure compliance, beginning the week of 4/5/2022, The Director of Nursing and/or Administrator will review 5 new admissions residents to ensure that a baseline care plan was developed within 48 hours of admission and included fall risk if applicable. This will be done on a 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) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate

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F 655	Continued From page 15	F 655	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), and Dietary Manager.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		4/4/22

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F 656	Continued From page 16 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 observations, record review, and staff interviews, the facility failed to develop a care plan for activities of daily living (ADLs) for 1 of 3 (Resident #13) residents reviewed for ADLs, failed to follow care plan interventions for 2 of 8 residents reviewed for falls (Residents # 68 and 60), and failed to develop a care plan for 1 of 1 (Resident #70) reviewed for activities. The findings included: 1. Resident #13 was admitted to the facility on 9/7/2021 with diagnoses that included Alzheimer's disease, hearing loss, and a history of a cerebral infarction. A review of the quarterly Minimum Data Set (MDS) assessment dated 12/15/2021 revealed she had severe cognitive impairment, was always incontinent of bowel and bladder and was totally dependent on staff for activities of daily living (ADLs) that included transfers, bed mobility and repositioning.	F 656	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F656 Develop/Implement Comprehensive Care Plan Corrective Action: Resident #13: Care plan reviewed and revised on 3/18/2022 by interdisciplinary team. Resident #68: Care plan reviewed and revised on 3/18/2022 by interdisciplinary team. Resident #60: Care plan reviewed and revised on 3/18/2022 by interdisciplinary team.	

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F 656	Continued From page 17 A review of the care plan section for Resident #13 revealed she did not have a focused area for ADLs. An interview was conducted with Nursing Assistant (NA) #1 on 3/15/2022 at 2:48 PM and revealed she had worked with Resident #13 as the assigned NA multiple shifts. She stated the Resident required two staff assist with transfers between the bed and chair via a mechanical lift and two staff assist with bed mobility. She added Resident #13 had used a mechanical lift for several months and she knew this information through report from a nurse or her Kardex. She was not able to locate the information in her tablet via the Kardex when requested to locate the information. An interview was conducted with Nurse #3 on 3/15/2022 at 2:51 PM and she revealed Resident #13 was recommended for a mechanical lift after a Physical therapy review was completed and two staff maximum assistance was recommended. She added this information was stored in a nursing communication book at the nursing station titled, "Resident Care Reference Book," as well as the Resident's care plan in Point Click Care (PCC). When requested to demonstrate Resident #13's care plan for ADL's Nurse #3 stated, she did not see one and when requested to demonstrate Resident #13 listed in the reference book, she added the Resident was not listed in the book under the mechanical lift section. An interview was conducted with the Director of Rehabilitation (DOR) on 3/15/2022 at 3:08 PM and she revealed on 12/9/2021 Resident #13 received a recommendation to be transferred via	F 656	Resident #70: Care plan Reviewed and revised on 3/18/2022 by interdisciplinary team. Identification of other residents who may be involved with this practice: All current residents with care plan interventions for activities of daily living, care plan interventions after a fall, care plan interventions for activities, have the potential to be affected by the alleged practice. On 3/29/2022 through 3/31/2022 an audit was completed by the Director of Nursing and Minimum Data Set Coordinators, to ensure that a care plan was implemented for current residents with care plan interventions for activities of daily living, care plan interventions after a fall and care plan interventions for activities, to ensure that the interventions were implemented as indicated on the plan of care. All current residents with a care plan intervention for activities of daily living, care plan interventions after a fall, care plan interventions for activities, have interventions implemented as indicated on the plan of care. This was completed on 3/31/2022. Systemic Changes: On 3/31/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the Minimum Data Set assessment process were in serviced /educated by the Director of Nursing. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	

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F 656	Continued From page 18 a mechanical hoyer lift to a broda chair and her bed mobility required the maximum assist of two staff members. She added the standard practice of the facility would be for this information to be communicated to the unit manager and MDS coordinator in the morning meetings in order for the Resident's care plan to be updated and staff to be educated. An interview was conducted with the MDS coordinator on 3/15/2022 at 3:23 PM and she reviewed the cognitive status of Resident #13 and stated she had severe cognitive impairment. She reviewed the ADL section of the MDS dated 12/15/2021 and stated the Resident required maximum assist of two staff members and then reviewed the care plan for the Resident and stated she did not see a focused area for ADLs. She added the Care Area Assessment (CAA), that coordinated with the 12/15/2021 MDS, should have triggered a focused care area for ADLs and did not. She was unsure why the CAA failed to trigger the care area and was going to report the failure to her Corporate Consultant and seek guidance. She stated the Resident needed a focused care plan for ADLs with Resident specific interventions to guide the NA's on the care they should provide the Resident. She stated she would add the focused area immediately and investigate the issue with the corporate consultant to avoid future issues. An interview was conducted with the Director of Nursing on 3/15/2022 at 3:48 PM and she revealed it was her expectation that Resident #13 had a focused area for ADLs and she would investigate the issue with the MDS coordinator. 2. Resident #68 was admitted on 5/29/2019 with	F 656	resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s preference and potential for future discharge, and discharge plans. A comprehensive person-centered care plan must be reviewed and implemented for all residents after a fall, for activities of daily living and for activities. This in-service was completed by 3/31/2022. Any Minimum Data Set nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance	

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F 656	Continued From page 19 diagnoses that included Alzheimer's disease, transient ischemia attack and hypertension. A review of the Minimum Data Set (MDS) dated 2/2/2022 revealed Resident #68 had severe cognitive impairment, required extensive assistance of two staff members with bed mobility and total assistance of two staff members with transfers. The Resident was always incontinent of bowel and bladder and was identified to have had one fall with major injury since the last assessment. A review of the fall incident report for Resident #68, dated 1/25/2022 at 14:38 revealed Resident #68 was observed lying face down on the floor, repeating, "get me up, get me up." Resident was assisted to her back and a new deformity was observed to her previously injured right arm. Resident was assessed, pain medication provided, MD and RP notified, and Resident sent out for treatment. The right humerus was fractured. A review of the Quality Assurance meeting notes dated 1/26/2022 revealed the interventions discussed by the interdisciplinary team included bilateral fall mats. A review of the care plan, dated 3/6/2022, revealed a focused area added to the care plan on 3/15/2022 that read, clarification intervention follow-up from the fall on 1/25/2022 bilateral fall mats while in bed. An observation was conducted on 3/14/2022 at 3:43 PM of Resident #68 lying in bed with one foot hanging off the bed and no fall mats in place. There was no fall prevention devices in place.	F 656	Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or designee will observe 5 residents with a interventions for falls care plan to ensure that care plan is implemented. The Director of Nursing and/or designee will observe 5 residents with a interventions for activities of daily living care plan to ensure that care plan is implemented. The Director of Nursing and/or designee will observe 5 residents with a interventions for activities care plan to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months beginning the week of 4/5/2022. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager.	

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An interview was conducted on 3/16/2022 at 10:50 AM with nursing assistant (NA) #4 and she revealed Resident #68 was care planned to have bilateral fall mats to each side of her bed while in bed and demonstrated where the fall mats were located in the room.
On 3/16/2022 at 1:57 PM an observation was conducted of Resident #68 lying in bed with eyes closed without a fall mat on the door side of the bed. Only one fall mat was on the floor, on the wall side.

An interview was conducted on 3/16/2022 at 2:00 PM with NA #4 and she revealed she forgot to place the second fall mat beside the bed for Resident #68, between the beds when she placed the Resident to bed. She added it must have slipped her mind. She then entered the room and placed the mat.

3. Resident #60 was admitted to the facility on 6/17/21 with diagnoses that included, in part, dementia, osteoarthritis and muscle weakness.

The quarterly Minimum Data Set (MDS) assessment dated 1/22/22 revealed Resident #60 had severe cognitive impairment. She required extensive assistance with transfers and during transfers, was only able to stabilize with staff assistance.

The care plan included a focused area of risk for and actual fall. A care plan intervention dated 3/3/22 stated, "Fall mats to both sides of bed."

A fall report dated 1/1/22 revealed Resident #60 was found on the floor next to her bed at 10:15 AM. Nursing staff completed an assessment

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which revealed no deformity and range of motion was within normal limits. The care plan was updated after the fall and floor mats were provided to both sides of the bed.

On 3/15/22 at 3:27 PM an observation of Resident #60's room revealed the resident was in her bed asleep. The bed was in the low position. A fall mat was on the floor next to the left side of the bed. There was no fall mat on the right side of the bed; however, there was a fall mat that stood up against the wall behind the headboard of Resident #60's bed.

Observations of Resident #60's room on 3/16/22 at 8:41 AM and 1:20 PM revealed the resident was in her bed. The bed was in the low position. A fall mat was on the floor next to the left side of the bed. There was no fall mat on the right side of the bed; however, there was a fall mat that stood up against the wall behind the headboard of Resident #60's bed.

During an interview with Nurse Aide (NA) #7 on 3/16/22 at 1:56 PM, she reported Resident #60 needed assistance from staff with walking and transferring. She said the resident often tried to get up on her own and usually had not asked for help from staff. She shared fall interventions the facility implemented for Resident #60 included placing the bed in a low position and fall mats to both sides of the bed when the resident was in bed. NA #7 stated she had rounded on the resident during the day but had not looked to make sure both fall mats were on the floor next to the bed. She acknowledged she was supposed to check that the fall mats were in place when Resident #60 was in bed but had not checked during rounds and missed that one of the fall

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mats had been placed up against the wall behind the resident's bed. NA #7 added that she had not typically checked the care plan for fall prevention interventions but reviewed the tasks that were listed for the resident or asked the nurse about any fall prevention interventions.

On 3/17/22 at 1:14PM an interview was completed with the MDS Nurse. She explained care plans were in Resident #60's electronic health record and nurses had access to the care plan and reviewed interventions for falls. She added NAs did not have access to care plan information unless the data pulled over to the NA's task list and stated not everything pulled over to the list. Staff were educated where to find care plan information and the MDS Nurse said NAs could also ask the nurses about care plan interventions.

The Director of Nursing (DON) was interviewed on 3/16/22 at 1:33 PM and on 3/17/22 at 1:23 PM. She reported after Resident #60 fell in January 2022, the facility implemented interventions that included a low bed, fall mats next to both sides of the bed and posted a sign on the resident's door which reminded the resident to call for staff assistance before transferring or walking. She verified fall prevention interventions were added to the care plan after Resident #60 fell. She explained if interventions were "flagged" to the NA task list, the NA reviewed the interventions and ensured they were in place when they worked with a resident. The DON said staff also reviewed fall prevention interventions when they gave report at shift change. She stated nurses also went into the electronic health record and looked at the care plan. After reviewing Resident #60's care

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plan, the DON reported she flagged the intervention about the fall mats to the NA task list. She specified staff were supposed to follow the care plan and implement the interventions.

4. Resident #70 was admitted to the facility on 1/17/2022 with diagnoses that included cataracts, depression, medically complex conditions, and moderate hearing loss.

A review of the admission Minimum Data Set (MDS) dated 1/24/2022 documented Resident #70 had hearing difficulty and required corrective lenses for reading.

A review of the activities assessment completed 1/25/2022 documented Resident #70 had poor vision and required glasses and was hard of hearing in both ears. Under the additional information tab it was documented the Resident reported her vision was not good due to her cataracts and her glasses did not help her to read any longer. Under the Resident's interest section, the Resident answered Reading was an interest. Under the question, how important is it to you to have books, newspapers, and magazines to read? The answer, Important but can't do it any longer was checked. How important is it for you to listen to music you like? Somewhat important was checked. How important is it for you to do your favorite activities? Very important. Under the section do you like to participate in group activities, the Resident stated, for very short time frames and in another area stated of little interest.

A review of the care plan dated 2/24/2022 revealed activities focus that read, I enjoy attending and participating in most activities at

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the facility with a goal to attend and participate in activities daily for 90 days and the intervention was that the Resident will be invited to participate in all group activities.
An interview was conducted with Resident #70 on 3/14/2022 and she revealed that she had been interviewed by someone from the activities department when she was admitted. She stated she told them she enjoyed reading but no longer could read books due to her vision and hearing being bad. She stated she loved reading. She denied anyone offering her books on tape. She asked how that would work with her roommate watching television so loudly. She denied being aware that books on tape could be listened to with a head set or ear buds. She denied being offered to listen to them in a different setting. She stated books on tape or music would be lovely. She stated she was bored and all she did was walk in the halls.

An interview was conducted with Nurse #6 on 3/17/2022 at 10:08 AM and she revealed she had been the assigned hall nurse for Resident #70 on several shifts. She revealed the Resident was slightly hard of hearing and it was difficult for the Resident to hear in large groups and background noise would make it hard for the Resident to hear. She stated she observes the Resident walk in the hall and sees her roommate's television on but does not see the Resident participate in any other activities.

An interview was conducted with the Activities Director on 3/17/2022 at 10:45 AM and reviewed the admission MDS and admission nursing assessment. She then reviewed the Resident's care plan and stated based on the care plan the Resident was encouraged to attend out of room

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F 656	Continued From page 25 activities. She then reviewed the activities assessment interview and revealed the Resident had revealed she was hard of hearing and had visual impairment and the glasses do not assist her to read or see due to her cataracts. She revealed the Resident stated reading was a favorite activity previously and that she could no longer do this activity. She revealed the Resident stated she enjoyed Music. She revealed the Resident stated doing her favorite activities were very important to her and that group activities were not important to her. She revealed that She did not have books on tape or such devices available and had not inquired from any local resources to obtain them or see if they would be available. She added she had offered music in the room, but a headphone type of option was not discussed that would allow her to hear it over the other noises. She stated this would be discussed with her. She added it was her expectation that the care plan reflects resident specific activities that had been answered in the interview.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		4/4/22

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F 657	Continued From page 26 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to update the care plan to 1. address a fall for 1 of 8 residents reviewed for accidents (Resident #92) and 2. address contracture management for 1 of 1 resident (Resident #72) reviewed for limited range of motion. The findings included: 1. Resident #92 was admitted to the facility on 2/8/2022 with diagnoses of anxiety, depression, and adjustment insomnia. An admission Minimum Data Set assessment dated 2/15/2022 revealed Resident #92 had moderately impaired cognition and required extensive assistance of 1-2 people for activities of daily living. He was non-ambulatory. Resident #2 had an indwelling catheter, was incontinent of bowel and used oxygen continuously. A nurse ' s note dated 3/10/2022 revealed	F 657	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 Care Plan Timing and Revision Corrective Action: Resident #92: Care plan for fall revised and updated on 3/16/2022 by the Director of Nursing. Resident #72: Care plan for contracture management revised and updated on 3/18/2022 by the Director of Nursing. Identification of other residents who may be involved with this practice:	

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F 657	Continued From page 27 Resident #92 was found on the floor. Resident #92 was very restless and has had no sleep this shift. A record review revealed no evidence Resident #92 ' s care plan was updated to include the fall that occurred on 3/10/2022. On 3/17/2022 at 3:20 PM, the Director of Nursing was interviewed. She stated the care plan should have been updated to include the fall and new interventions put into place. She stated she thought she updated the care plan herself but could not find evidence the care plan was updated. 2. Resident #72 was admitted to the facility on 3/22/21 with diagnoses that included, in part, dementia and polyosteoarthritis. An occupational therapy (OT) discharge summary dated 12/14/21 and authored by OT #1, stated, in part, "Seen for bilateral hand contractures and implemented hand grip splints during therapy treatment sessions. Upon discharge, the OT recommendation was for resident to wear the hand splints daily for six hours. Education and training were provided to staff in splinting/orthotic schedule, safety precautions and self-care/skin checks in order to wear splints." The annual Minimum Data Set (MDS) assessment dated 1/22/22 revealed Resident #72 had impaired memory and severely impaired daily decision making skills. She had impairment on both sides of her upper extremity. The care plan, updated 2/28/22, revealed a focused area of	F 657	All current residents with an actual fall; all current residents with contractures have the potential to be affected by the alleged practice. On 3/29/2022 through 3/31/2022 an audit was completed by the Director of Nursing to ensure that a care plan was implemented for current residents with an actual fall; and current residents with contractures. Current residents with contractures have updated care plans, and all current residents with actual falls have updated care plans. This was completed on 3/31/2022. Systemic Changes: On 3/31/2022 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the Minimum Data Set assessment process was in serviced /educated by Director of Nursing. The education focused on: The facility must develop, implement, review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized	

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F 657	Continued From page 28 activities of daily living. An intervention included, "Will receive staff assistance with all aspects of daily care..." Further review of the care plan revealed no focused area or interventions that addressed contracture management. An observation of Resident #72 was completed on 3/14/22 at 2:41 PM. The resident was in bed and her hands were on top of the bed covers. The right and left hands were observed to be flexed inward, with fingers folded towards the palms of the hands. Resident #72 was non-verbal and unable to follow commands when asked to straighten out her fingers. The Director of Rehabilitation Services (DRS) was interviewed on 3/15/22 at 2:57 PM and stated Resident #72 was treated by occupational therapy for hand contractures from 10/18/21-12/14/21. She shared therapy had utilized a palm guard splint to both of the residents' hands. Upon discharge from therapy, nursing staff were educated and trained on the application of the palm guard splints to Resident #72's hands. In an interview with the MDS Nurse on 3/16/22 at 1:45 PM, she explained when therapy discharged a resident from their service they educated staff and completed a functional maintenance program form with any splinting instructions which was forwarded to the MDS Nurse. The information on the form was then added to the resident's care plan. MDS Nurse said she was unable to locate the instruction form for Resident #72 but stated the therapy department had educated staff on the palm guard splints for the resident. She added if she had received the maintenance program form she would have updated the care plan to reflect	F 657	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 develop, implemented, reviewed and revised upon admission, readmission and with any change in condition. This in service was completed by 3/31/2022. Any Minimum Data Set nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, beginning the week of 4/5/2022, The Director of Nursing and/or designee will observe 5 residents who have contractures to ensure that care plan is reviewed /revised. The Director of Nursing and/or designee will observe 5 residents with actual falls to ensure that care plan is reviewed /revised. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented	

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F 657	Continued From page 29 the usage of splints to Resident #72's hands. The Director of Nursing (DON) was interviewed on 3/16/22 at 1:22 PM. She said if a resident had contractures it should be addressed in the care plan since the contractures affected how staff provided care to the resident.	F 657	to the weekly QA Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility failed to 1. Obtain orders for care of a central intravenous line for 1 of 1 resident reviewed for dialysis (Resident #254) and 2. Ensure physician orders for treatment of a pressure ulcer were accurate for 1 of 4 residents reviewed for pressure ulcers (Resident #253). The findings included: 1. A review of Resident #254 ' s discharge summary dated 1/13/2022 included follow-up	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 Professional Standards	4/4/22

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instructions for removal of her left central intravenous line.

Resident #254 was admitted to the facility on 1/13/2022 with diagnoses of, in part, end stage renal disease.

A Nurse Admission Review dated 1/13/2022 revealed Resident #254 had a central venous line place to left chest.

An admission Minimum Data Set assessment dated 1/20/2022 revealed Resident #254 had intact cognition and required extensive assistance of 1-2 people for activities of daily living.

A review of the physician ' s orders for January through March 2022 included no orders for care and treatment of the left central intravenous line.

On 3/14/2022 at 12:10 PM Resident #254 was interviewed. She stated the hospital was supposed to remove the central line to her left chest before she left the hospital but the couldn ' t because her Eliquis had not been held and it needed to be held for 2-3 days prior to the procedure.

On 3/15/2022 at 3:15 PM, an intravenous site was observed to Resident #254 ' s left chest. Resident #254 ' s family member was in room and stated it was a month before anyone changed the dressing. Resident #254 agreed and stated Nurse #6 changed the dressing last Wednesday and the Wednesday before that. She stated no one else has changed the dressing.

On 3/15/2022 at 3:25 PM, an interview was conducted with Unit Manager #1 who stated the

Corrective action for resident(s) affected by the alleged deficient practice:
On 3/18/2022, the Director of Nursing (DON) assessed resident #254 then notified the medical provider and obtained treatment orders for central line. On 3/18/2022, the physician order was clarified for the sacral ulcer by the DON.
Corrective action for residents with the potential to be affected by the deficient practice
On 3/28/2022, the Administrator completed a 100 % audit of all current residents with central lines in order to validate that the residents have orders for care of central line. The results of the audit were that there are no other central lines in facility. On 3/30/2022. The Director of Nursing completed a 100% audit of all facility pressure areas to ensure orders were accurate for current wound.
Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 3/22/2022, the Director of Nursing began educating all full time, part time, and prn nurses, and agency licensed staff on the following topics: professional standards on the importance of making sure residents have treatment orders in place at time of initiation of central line and to ensure accurate treatments in place for wound care. If training is not completed by 4/4/2022 the employee will not be allowed to work until completed. The Director of Nursing will ensure that newly hired nurses and agency nurses who have not completed education by 4/4/2022, will not be allowed to work until

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F 658	Continued From page 31 central line to Resident #254 ' s chest was scheduled to be removed so there were no orders for care and treatment of the site. On 3/17/2022 at 3:03 PM, an interview was conducted with the facility physician who stated they were trying to get the left central line removed since she was admitted because she wasn ' t using it. He stated someone had changed the dressing but agreed there should be orders in place for care and treatment of the site. On 3/17/22 at 3:20 PM, an interview was conducted with the Director of Nursing who stated orders should have been put in place on admission for care and treatment of Resident #254 ' s central line. 2. Resident #253 was admitted to the facility on 3/1/2022 with diagnoses of displaced intertrochanteric fracture to right femur and heart failure. An admission Minimum Data Set dated 3/8/2022 revealed Resident #253 had moderately impaired cognition, required extensive assistance of 2 people for bed mobility, transfers and toileting. Resident #253 was at risk of pressure ulcer development and had a current stage 2 pressure ulcer. She had a pressure reduction device to her bed and received pressure ulcer care. The care plan included a focus area of current pressure ulcer to sacrum and risk for development of additional pressure ulcers due to decreased ability to re-position and bowel and bladder incontinence. Interventions included administer treatments as ordered.	F 658	it has been completed Education on professional standards has been incorporated into new hire and agency orientation. All agency nurses utilized by the facility will receive education on Professional Standards 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. Beginning the week of 4/5/2022, the Director of Nursing or designee will monitor compliance utilizing F-tag 658 Professional Standards monitoring QA tool. Observation will include observations of central lines and pressure areas for 5 residents 3 x week x 2 weeks, then weekly x 3 months. The ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, MDS Coordinator, Therapy Manager, Health Information Manager, and the/ Dietary Manager.	

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F 658	Continued From page 32 A physician ' s order dated 3/11/2022 read, in part "clean areas on right and left buttock". On 3/16/2022 at 10:05 AM, an observation of wound care for Resident #253 was conducted with Nurse #2. Resident #253 had an unstageable area to her sacral area. No other pressure areas were observed. Nurse #2 confirmed no open areas to Resident #253 ' s buttocks. On 3/17/2022 at 3:20 PM, an interview was conducted with the Director of Nursing. She stated orders for treatments should be accurate to include the correct location.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to reposition and provide incontinence care to 1 of 3 (Resident # 13) residents reviewed for activities of daily living (ADL). The findings included: Resident #13 was admitted to the facility on 9/7/2021 with diagnoses that included Alzheimer's disease, hearing loss, and a history of a cerebral infarction. A review of the quarterly Minimum Data Set	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-677 ADL Care Provided for Dependent Residents	4/4/22

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F 677	Continued From page 33 (MDS) assessment, dated 12/15/2021, revealed Resident #13 had severe cognitive impairment, was always incontinent of bowel and bladder and was totally dependent on staff for activities of daily living (ADLs) that included transfers, bed mobility, repositioning and personal hygiene. A review of the care plan section for Resident #13 revealed she did not have a focused area for ADLs. An observation was conducted on 3/14/2022 at 2:52 PM of Resident #13 sitting in her room, in front of the wardrobe/closet area, with her call bell across her room, a strong lingering odor of urine was present. A mechanical lift pad was underneath her and a wet stain was visible about 2 inches around her bottom, and she was wet through her pants on the front side with the brief area swollen and bulging. An interview was conducted with Nursing Assistant (NA) #6 on 3/14/2022 at 2:58 PM and she revealed she was assigned to Resident #13 since 12 PM and the NA that had been assigned from 7 AM through 12 PM had left to go on an appointment with another resident. She added that during the morning, she and the other NA had assisted each other for all residents that required 2 staff assist. She stated she had not repositioned or completed peri-care on Resident #13 since she took over the assignment. She did not know what the other NA had done but she did not assist the NA in the morning to lay the Resident down and complete the peri-care. She revealed that the Resident was already up to the Broda chair prior to her arrival at 7 AM because 3rd shift gets her up in the mornings. She	F 677	Corrective Action for Affected Residents For resident #13 incontinent care provided by Nurse Aide (NA) #6 with assistance from 2 additional NA on 3/14/2022 Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 3/28/2022, Nurse Managers audited all current residents for toileting and incontinent care needs. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned Nurse Aide. Systemic Changes On 3/22/2022, the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's and agency staff this in-service included the following topics: " ADL Care for Dependent Resident " Performing Incontinent/Perineal Care per Plan of Care If training is not completed, The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 4/4/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.	

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F 677	Continued From page 34 observed the Resident and stated she saw a large wet area to her pants, a swollen brief area that indicated it was wet and would get someone that was coming on for second shift to help her provide the needed care immediately. An interview was conducted with the Director of Nursing (DON) on 3/14/2022 at 4:12 PM and she revealed it was her expectation that all residents be repositioned according to their care plan and receive peri-care as needed.	F 677	Quality Assurance Beginning the week of 4/5/2022, The Director of Nursing or designee will monitor this issue using the F-677 Quality Assurance Tool for Monitoring ADL Care for Dependent Residents. The monitoring will include reviewing a sample of at least 5 residents for toileting and incontinent care needs. This will be completed 3 x weekly for 2 weeks then weekly times 3 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing 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, Unit Support Nurse, Minimum Data Set Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		4/4/22

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F 679	Continued From page 35 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to provide a resident specific activity program that met the individual interest and needs to enhance the quality of life for 1 of 1 (Resident #70) residents reviewed for activities. The findings included: Resident #70 was admitted to the facility on 1/17/2022 with diagnoses that included cataracts, depression, medically complex conditions, and moderate hearing loss. A review of the admission Minimum Data Set (MDS) dated 1/24/2022 documented Resident #70 had hearing difficulty and required corrective lenses for reading. A review of the activities assessment completed 1/25/2022 documented Resident #70 had poor vision, required glasses and was hard of hearing in both ears. Under the additional information tab it was documented the Resident reported her vision was not good due to her cataracts and her glasses did not help her to read any longer. Under the Resident's interest section, the Resident answered reading was an interest. Under the question, how important is it to you to have books, newspapers, and magazines to read? The answer, Important but can't do it any longer was checked. How important is it for you to listen to music you like? Somewhat important was checked. How important is it for you to do your favorite activities? Very important. Under the section do you like to participate in group	F 679	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F679 Activities Meet Interest/Needs Each Resident Corrective Action: For resident #70, On 3/18/2022, the resident was assessed and the facility ordered a variety of head phones for resident to use listening to books on tape. The resident care plan was updated to reflect the intervention Corrective Action for Potentially Affected Residents; All residents have potential to be affected by the deficient practice. On 3/28/2022 through 3/30/2022, all current resident care plans and interest were reviewed. The Activities Director updated resident Care Plans to reflect activities to meet the needs and interest of residents. Systemic Changes: On 3/23/2022, the Administrator in serviced the Activities staff related to providing resident needs and interest to enhance quality of life. This training is incorporated into the new employee	

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F 679	Continued From page 36 activities, the Resident stated, for very short time frames and in another area stated of little interest. A review of the care plan dated 2/24/2022 revealed an activities focus that read, I enjoy attending and participating in most activities at the facility with a goal to attend and participate in activities daily for 90 days and the intervention was that the Resident will be invited to participate in all group activities. An interview was conducted with Resident #70 on 3/14/2022 at 11:03 AM and she revealed that she had been interviewed by someone from the activities department when she was admitted. She stated she told them she enjoyed reading but no longer could read books due to her vision and hearing being bad. She stated she loved reading. She denied anyone offering her books on tape. She asked how that would work with her roommate watching television so loudly. She denied being aware that books on tape could be listened to with a head set or ear buds. She denied being offered to listen to them in a different setting. She stated books on tape or music would be lovely. She stated she was bored and all she did was walk in the halls. An observation was conducted on 3/15/2022 at 10:43 AM of the Resident lying in bed staring at the window. She rolled over, sighed, stood up and walked out of the door. An observation was conducted on 3/15/2022 at 10:58 AM of Resident #70, when she returned from walking the hall, she entered her room and stated, "I am bored." An interview was conducted with Nurse #6 on 3/17/2022 at 10:08 AM and she revealed she had	F 679	orientation program. Any new staff will be in-serviced as part of their facility orientation. Quality Assurance 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; Beginning the week of 4/5/2022, the Administrator will monitor compliance using a quality assurance (QA) survey tool Activities to Meet Needs/Interest of Resident. This will be done 3 x weekly x 2 weeks then weekly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Activity Director	

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F 679	Continued From page 37	F 679		

been the assigned hall nurse for Resident #70 on several shifts. She revealed the Resident was slightly hard of hearing and it was difficult for the Resident to hear in large groups and background noise would make it hard for the Resident to hear. She stated she observes the Resident walk in the hall and sees her roommate's television on but does not see the Resident participate in any other activities.

An interview was conducted with the Activities Director on 3/17/2022 at 10:45 AM and she reviewed the admission MDS and admission nursing assessment. She then reviewed the Resident's care plan and stated based on the care plan the Resident was encouraged to attend out of room activities. She then reviewed the activities assessment interview and revealed the Resident had revealed she was hard of hearing and had visual impairment and the glasses do not assist her to read or see due to her cataracts. She revealed the Resident stated reading was a favorite activity previously and that she could no longer do this activity. She revealed the Resident stated she enjoyed Music. She revealed the Resident stated doing her favorite activities were very important to her and that group activities were not important to her. She revealed that She did not have books on tape or such devices available and had not inquired from any local resources to obtain them or see if they would be available. She added she had offered music in the room, but a headphone type of option was not discussed that would allow her to hear it over the other noises. She stated this would be discussed with her. She added it was her expectation that a resident be offered activities per their individual preferences and choices and she would work with Resident #70.

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F 686 SS=D	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 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 observations, record review, family member, staff and physician interviews, the facility failed to assess and implement interventions for pressure ulcer prevention for newly acquired heel redness for 1 of 4 residents reviewed for pressure ulcers (Resident #253). The findings included: Resident #253 was admitted to the facility on 3/1/2022 with diagnoses of displaced intertrochanteric fracture of right femur, chronic kidney disease and congestive heart failure. An admission Minimum Data Set assessment dated 3/8/2022 revealed Resident #253 had moderate cognitive impairment. She required extensive assistance with two people for bed mobility, transfers and toileting. She was non-ambulatory. The assessment indicated Resident #253 had a current stage 2 pressure	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer Corrective action for resident(s) affected by the alleged deficient practice: On 3/17/2022 the Director of Nursing assessed resident #253 skin and notified MD and initiated and implemented orders for prevention of skin breakdown. Corrective action for residents with the	4/4/22

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F 686	Continued From page 39 ulcer and was at risk for pressure ulcer development. Resident #253 received pressure ulcer care and had a pressure reduction device to her bed. A review of the care plan revealed a focus area of currently pressure and at risk for development of additional pressure ulcers due to decreased ability to re-position and incontinence. Interventions included, in part, notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises or discoloration noted during bath or daily care and weekly full body assessments. A skin assessment dated 3/8/2022 revealed an existing pressure ulcer. No other areas were documented. A wound evaluation from the wound care physician dated 3/10/2022 revealed an unstageable area to Resident #253 ' s sacrum and a stage 2 area to the upper back. A review of Resident #253 ' s March 2022 physician ' s orders included treatment orders to her sacral and upper back pressure areas. On 3/14/2022 at 11:45 AM, Resident #253 was observed lying in bed. A heel protector was observed to the right foot. The left foot was observed to be lying flat on the mattress. On 3/14/2022 at 11:45 AM, Resident #253 ' s family member was interviewed. He stated Resident #253 had a red heel and "they" said they were going to get something for it but haven ' t yet. On 3/16/2022 at 10:05 AM, an observation of	F 686	potential to be affected by the deficient practice: All residents have potential to be affected by the deficient practice. On 3/30/2022, the Director of Nursing reviewed 100 % of current resident records Braden score of 14 or less to ensure appropriate treatment and interventions were in place. There were 38 residents with a Braden score of less than 14. These 38 the resident records were reviewed and updated accordingly to reflect interventions to prevent skin breakdown. Systemic Changes: On 3/22/2022, the Director of Nursing began educating all full time, part time, and prn nurses, medication aides, nurse aides and agency staff on the following topic: " Pressure Ulcer Prevention Any clinical staff (full time, part time, PRN, and agency) who did not receive in-service training by 4/4/2022 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation. Quality Assurance: Beginning the week of 4/5/2022, The Director of Nurses or designee will monitor Compliance using the QA Tool for Pressure Ulcer Prevention. Monitoring will include observation of residents with Braden scale less than 14 to ensure	

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F 686	Continued From page 40 Resident #253 ' s wound care was conducted. Upon entering the room, Resident #253 was observed lying in bed with her left heel lying flat on the mattress. Nurse #2 completed the wound care to Resident #253 ' s back and sacral wounds then was asked by the surveyor to observe her heels. Resident #253 ' s entire left heel was reddened. Nurse #2 observed the skin to blanch with pressure. Nurse #2 was not observed to apply a treatment to the left heel of float the heel off the mattress. On 3/16/2022 at 11:10 AM, an interview was conducted with Nurse #2. She stated she identified the redness to Resident #253 ' s left heel on Sunday, March 13, 2002. She stated she floated the resident ' s heel but did not put anything else in place. On 3/16/2022 at 11:15 AM, Unit Manager #1 was interviewed. She stated she thought the wound care physician saw the resident ' s heel when he last rounded and was not concerned. On 3/16/2022 at 2:35 PM, an interview was conducted with NA #2. She stated she had not worked since last week and did not know anything about Resident #253 having heel redness. On 3/17/2022 at 11:30 AM, the Wound Care Physician was interviewed. He stated he looks at heels when he makes rounds and was certain that Resident #253 could not have had a reddened left heel last week when he rounded on 3/10/2022. He stated he only documented a bootie was in place but could not say if it was for one or both heels. He added heels should be in a boot or off loaded for residents at risk for	F 686	interventions are in place. Monitoring will be for 5 residents weekly times 4 weeks and then monthly times 2 months. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 686	Continued From page 41 pressure ulcer development. On 3/17/2022 at 3:20 PM, the Director of Nursing was interviewed. She stated Nurse #2 should have documented the redness to Resident #253 ' s heel when it was first noticed, and interventions should have been put into place for care and treatment.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide application of bilateral palm guard splints according to therapy recommendations for 1 of 1 resident (Resident #72) reviewed for limited range of motion.	F 688	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	4/4/22

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F 688	Continued From page 42 Findings included: Resident #72 was admitted to the facility on 3/22/21 with diagnoses that included, in part, dementia and polyosteoarthritis. An occupational therapy (OT) discharge summary dated 12/14/21 and authored by OT #1, stated, in part, "Seen for bilateral hand contractures and implemented hand grip splints during therapy treatment sessions. Upon discharge, the OT recommendation was for resident to wear the hand splints daily for six hours. Education and training were provided to staff in splinting/orthotic schedule, safety precautions and self-care/skin checks in order to wear splints." The annual Minimum Data Set (MDS) assessment dated 1/22/22 revealed Resident #72 had impaired memory and severely impaired daily decision making skills. She had impairment on both sides of her upper extremity. The care plan, updated 2/28/22, revealed a focused area of activities of daily living. An intervention included, "Will receive staff assistance with all aspects of daily care..." An observation of Resident #72 was completed on 3/14/22 at 2:41 PM. The resident was in bed and her hands were on top of the bed covers. The right and left hands were observed to be flexed inward, with fingers folded towards the palms of the hands. Resident #72 was non-verbal and unable to follow commands when asked to straighten out her fingers. There was no hand splinting device located in Resident #72's room. The Director of Rehabilitation Services (DRS)	F 688	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. F688 Increase/Prevent Decrease in ROM/Mobility Corrective action for affected residents. On 3/16/2022, therapy evaluation was completed to evaluate and treat resident #72 related to contracture to bilateral hands. Resident #72 is currently on OT caseload for contracture management. Corrective action for potentially affected residents. All residents who utilize a splint for contractures have the potential to be affected by the alleged deficient practice. On 3/31/2022, the Director of Nursing audited all current residents with contractures to ensure they were wearing splints per therapy recommendation. The facility currently has 4 residents with contractures, all 4 residents are currently on therapy caseload for splint evaluation. Systemic changes On 3/22/2022, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: --The importance for applying splints, palm guards, and hand rolls as recommended by therapy. --What to do and who to notify if resident refuses to wear splint. -- What to do when the device cannot be located. -- How staff will be educated on use of the splint--therapy will educate CNA staff with	

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F 688	Continued From page 43 was interviewed on 3/15/22 at 2:57 PM and on 3/16/22 at 9:13 AM and stated Resident #72 was treated by occupational therapy for hand contractures from 10/18/21-12/14/21. She shared therapy had utilized a palm guard splint to both of the residents' hands. Upon discharge from therapy, nursing staff were educated and trained on the application of the palm guard splints to Resident #72's hands. The DRS added the therapy department typically had not entered orders in the resident's chart regarding splinting devices. During an interview with Nurse Aide (NA) #2 on 3/16/22 at 10:51 AM, she stated she had worked with Resident #72 and was familiar with her care. She explained if a resident needed a splinting device, she was notified by nursing staff or therapy staff when they gave report at the change of shift. NA #2 was not aware of any splints that were to be applied to Resident #72's hands. She added she looked at the ADL task list daily when she completed her charting and the task list indicated if a resident required any type of splinting device. NA #2 reviewed the ADL task list in the computer for Resident #72 and said there was no information regarding splinting to the residents' hands. Nurse #4 was interviewed on 3/15/22 at 3:34 PM. She was familiar with Resident #72's care and shared if there was a splint that was to be placed on the resident there would be an order in the chart. Nurse #4 reviewed Resident #72's medical record and said there was no order in the chart for a splint application to the residents' hands. On 3/15/22 at 3:31 PM an interview was completed with Unit Manager #1. She explained	F 688	the resident and brightly colored splint education and application folder will be placed in each room for residents with splints. -- How therapy recommendation will be communicated to nursing--Functional Maintenance Program form-- a copy will be given to Administrator, Director of Nursing, and MDS RN. --Therapy will enter own splint orders into the resident record. The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 4/4/2022 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 Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance Beginning on the week of 4/5/2022 The Director of Nursing or designee will monitor this issue using the F688 Quality Assurance Tool for Splints. The monitoring tool will observe for the communication form, orders entered into medical record, splint education/application folder in resident room, and splint is in use. This will be completed 3 x weekly for 2 weeks then	

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F 688	Continued From page 44 if a resident wore a splinting device there was an order in the chart. Unit Manager #1 stated she was not aware if staff had applied any splints to Resident #72's hands. Occupational Therapy Assistant (OTA) #1 was interviewed on 3/16/22 at 10:28 AM. She recalled Resident #72's hands were contracted and said she worked with the resident in December 2021. OTA #1 stated she placed palm guard splints in the resident's hands as part of treatment in therapy. During treatment and at the time therapy was discontinued, OTA #1 educated nursing staff to donn the splints daily to both hands for "no longer than six hours." She added therapy had not typically entered orders for splinting devices. An observation of Resident #72 with OTA #1 at 10:35 AM revealed the resident was resting in bed and there were no splints on her hands. OTA #1 described Resident #72's hands as "having contraction" and OTA #1 assisted Resident #72 with opening her hands enough that a splinting device could be applied. OTA #1 looked through the resident's room during the observation and was unable to locate the palm guard splints. In an interview with the MDS Nurse on 3/16/22 at 1:45 PM, she explained when therapy discharged a resident from their service they educated staff and completed a functional maintenance program form with any splinting instructions which was forwarded to the MDS Nurse. MDS Nurse said she was unable to locate the instruction form for Resident #72 but stated the therapy department had educated staff on the palm guard splints for the resident. A follow up interview was completed with the DRS on 3/16/22 at 2:53 PM, during which she stated	F 688	weekly times 3 months or until resolved to ensure their needs are met 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, Minimum Data Set Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 688	Continued From page 45 the therapy department had not recommended a functional maintenance program for Resident #72 because they thought all the resident needed was for staff to donn the palm guard splints during morning care as instructed by the therapist when Resident #72 was discharged from therapy caseload. The Director of Nursing (DON) was interviewed on 3/16/22 at 1:22 PM. She explained the facility process was that therapy gave a referral sheet to the MDS Nurse that included information on where to donn splints and the duration of the splints. Nursing then placed an order in the chart which displayed on the medication administration record (MAR) and the nurse checked it off during the shift. The DON acknowledged that splinting had not been in place for Resident #72 and the splints had been located in the laundry department. She did not know how long Resident #72 had not worn the palm guard splints. The DON added she thought maybe the staff who were educated by therapy in December 2021 might no longer be employed at the facility and "there might be new staff." She stated the therapy department should have completed a referral form and forwarded it to nursing when they discharged the resident from therapy services.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		4/4/22

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F 689	Continued From page 46 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide intervention for fall prevention for 2 of 8 residents (Residents #60 and 68) reviewed for falls. Findings included: 1. Resident #60 was admitted to the facility on 6/17/21 with diagnoses that included, in part, dementia, osteoarthritis and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 1/22/22 revealed Resident #60 had severe cognitive impairment. She required extensive assistance with transfers and during transfers, was only able to stabilize with staff assistance. The care plan included a focused area of risk for and actual fall. A care plan intervention dated 3/3/22 stated, "Fall mats to both sides of bed." A fall report dated 1/1/22 revealed Resident #60 was found on the floor next to her bed at 10:15 AM. Nursing staff completed an assessment which revealed no deformity and range of motion was within normal limits. The care plan was updated after the fall and floor mats were provided to both sides of the bed. On 3/15/22 at 3:27 PM an observation of Resident #60's room revealed the resident was in her bed asleep. The bed was in the low position. A fall mat was on the floor next to the left side of the bed. There was no fall mat on the right side	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 Free of Accidents Hazards/Supervision/Devices Corrective action for resident(s) affected by the alleged deficient practice: On 3/16/2022, resident #60 and resident #68 were assessed by the Director of Nursing to determine that bilateral fall mats remained appropriate device for fall prevention and bilateral fall mats were placed at both resident bedsides. The Director of Nursing placed the fall mats on the Nurse aide (NA) Kardex and on the NA Point of Care for each shift. Corrective Action for Potentially Affected Residents. All residents in the facility who are at risk or have had falls, have the potential to be affected by the alleged deficient practice. On 3/29/2022, the Director of Nursing completed a safety audit for all current residents ordered fall mats. The Director of Nursing ensured that all mats were available and in place and placed the fall	

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of the bed; however, there was a fall mat that stood up against the wall behind the headboard of Resident #60's bed.

Observations of Resident #60's room on 3/16/22 at 8:41 AM and 1:20 PM revealed the resident was in her bed. The bed was in the low position. A fall mat was on the floor next to the left side of the bed. There was no fall mat on the right side of the bed; however, there was a fall mat that stood up against the wall behind the headboard of Resident #60's bed.

During an interview with Nurse Aide (NA) #7 on 3/16/22 at 1:56 PM, she reported Resident #60 needed assistance from staff with walking and transferring. She said the resident often tried to get up on her own and usually had not asked for help from staff. She shared fall interventions the facility implemented for Resident #60 included placing the bed in a low position and fall mats to both sides of the bed when the resident was in bed. NA #7 stated she had rounded on the resident during the day but had not looked to make sure both fall mats were on the floor next to the bed. She acknowledged she was supposed to check that the fall mats were in place when Resident #60 was in bed but had not checked during rounds and missed that one of the fall mats had been placed up against the wall behind the resident's bed.

The Director of Nursing (DON) was interviewed on 3/16/22 at 1:33 PM. She recalled Resident #60's fall in January 2022 and stated the resident was in a wheelchair next to the bed. The NA had left the room to obtain linens and during the time the NA was out of the room the resident got out of the wheelchair, walked around the foot of the bed

mats in the NA Kardex and on the NA Point of Care for each shift.
Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
On 3/22/2022, the Director of Nursing began an in-service education to all full time, part time, agency, and as needed nurses, medication aides, and nurse aides regarding which residents had fall interventions and which type of intervention was required. Also, education included informing nurse management regarding resident falls for implementation of intervention. Any nursing staff not in-serviced by 4/4/2022 will not be able to work until trained. Any new staff or agency staff will be in-serviced as part of their facility orientation.
Quality Assurance-
The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Accidents and Supervision beginning the week of 4/5/2022. The monitoring will include resident observation of 5 residents ordered fall interventions including fall mats. This will be completed 5 x week for 2 weeks then weekly x 3 months or until resolved to ensure fall interventions are in place. Reports will be given to the Monthly QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, Minimum Data Set Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director.

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and fell. After the fall, the facility implemented interventions that included a low bed, fall mats next to both sides of the bed and posted a sign on the resident's door which reminded the resident to call for staff assistance before transferring or walking. An observation of Resident #60's room with the DON on 3/16/22 at 1:39 PM revealed the resident was in bed and the bed was in a low position. A fall mat was observed on the floor to the left of the resident's bed. A second fall mat was observed as it leaned up against the wall behind the headboard of Resident #60's bed. There was no fal mat on the floor on the right side of the bed. The DON commented that when Resident #60 was in bed, both fall mats were supposed to be on the floor on either side of the bed. She added whomever placed Resident #60 in bed was responsible to ensure the fall mats were on the floor on both sides of the bed.

2. Resident #68 was admitted to the facility on 5/29/2019 with diagnoses that included Alzheimer's disease, anxiety, and epilepsy.

A review of the quarterly Minimum Data Set (MDS), dated 2/2/2022, revealed Resident #68 had severe cognitive impairment and required extensive assistance of two staff members with bed mobility and total assistance of two staff members for transfers from bed to a chair. The assessment documented she had a fall with major injury since the last MDS assessment.

A review of the fall incident report for Resident #68, dated 1/25/2022 at 14:38 revealed Resident #68 was observed lying face down on the floor, repeating, "get me up, get me up." Resident was

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assisted to her back and a new deformity was observed to her previously injured right arm. Resident was assessed, pain medication provided, MD and RP notified, and Resident sent out for treatment. The right humerus was fractured.

A review of the Quality Assurance meeting notes dated 1/26/2022 revealed the interventions discussed by the interdisciplinary team included bilateral fall mats.

A review of the care plan, dated 3/6/2022, revealed a focused area added to the care plan on 3/15/2022 that read, clarification intervention follow-up from the fall on 1/25/2022 bilateral fall mats while in bed.

An observation was conducted on 3/14/2022 at 3:43 PM of Resident #68 lying in bed with one foot hanging off the bed and no fall mats in place. There was no fall prevention devices in place. An interview was conducted on 3/16/2022 at 10:50 AM with nursing assistant (NA) #4, with the Director of Nursing present, and the NA revealed Resident #68 was care planned to have bilateral fall mats to each side of her bed while in bed and demonstrated where the fall mats were located in the room.

On 3/16/2022 at 1:57 PM an observation was conducted of Resident #68 lying in bed with eyes closed without a fall mat on the door side of the bed. Only one fall mat was on the floor, on the wall side.

An interview was conducted on 3/16/2022 at 2:00 PM with NA #4 and she revealed she forgot to place the second fall mat beside the bed for

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F 689	Continued From page 50 Resident #68, between the beds when she placed the Resident to bed. She added it must have slipped her mind. She then entered the room and placed the mat.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to lock an unattended medication cart for 1 of 4 medication carts (hall 400) observed.	F 761	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	4/4/22

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F 761	Continued From page 51 The findings included: An observation on 3/14/22 at 11:25 AM revealed Nurse #1 walking away out of eyesight from the medication cart on the 400 hall. The medication cart lock was not pushed in indicating a locked position. An interview on 3/14/22 at 11:35 AM with Nurse #1 revealed she walked away from the medication cart to retrieve a stock medication from the medication room and left the cart unlocked. She stated she knew she was supposed to lock the medication cart when unattended, but she got nervous and just forgot to do so. In an interview with the Administrator on 3/17/22 at 9:48 AM, she shared that she immediately spoke with Nurse #1 after the incident and stated that all nurses and med techs were aware that when they stepped away from a medication cart, it should be in the locked position. The Administrator added they were in the process of completing an in-service reminding staff the importance of locking the medication carts when walking away from it for any length of time.	F 761	compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-761 Label/Store Drugs & Biologicals Corrective action for affected residents. On 3/14/2022, Nurse #1 locked and secured medication cart upon being notified it was not locked. On 3/14/2022, the Administrator reeducated nurse #1 related to medication storage and securing medication cart before leaving it. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications or supplements have the potential to be affected by the alleged deficient practice. On 3/22/2022, the Administrator and Director of Nursing completed audit by rounding on all halls to ensure all medication carts were locked and all medications were stored and secured properly. The findings were that all carts were locked. Systemic Change: On 3/22/2022, the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and medication aides. This in-service included the following topics: " Ensuring medication carts are locked and secure when unattended The Director of Nursing will ensure that any licensed facility or agency nurse or	

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F 761	Continued From page 52	F 761	medication aide who has not received this training by 4/4/2022 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. 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. Any newly hired licensed nurse or medication aide (full-time, part-time or PRN) who does not receive scheduled in-service training will not be allowed to work until training has been completed. In addition to this, any agency nurse utilized by the facility will receive this in-service education prior to their shift. Quality Assurance: The Director of Nursing or designee will monitor compliance utilizing the Medication Storage Quality Assurance Tool 3 x weekly x 2 weeks then weekly x 3 months. The DON or designee will monitor for compliance with labeling medications and supplements with a date when opened and ensuring the cart and the medication room is free of expired medications. 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	

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F 761	Continued From page 53	F 761	Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		4/4/22

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F 791	Continued From page 54 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews the facility failed to follow-up with dental services when the broken tooth of 1 of 1 sampled resident was not extracted as scheduled. Resident #63 Findings included: Resident #63 was admitted to the facility on 8/5/21 with diagnoses which included diabetes mellitus with diabetic polyneuropathy, congestive heart failure and chronic obstructive pulmonary disease. The physician's order 8/5/21 revealed Resident #63 was prescribed Eliquis (anticoagulant medication) related to the diagnosis of paroxysmal atrial fibrillation. The quarterly minimum data set dated 1/26/22 indicated Resident #63 was cognitively intact and had no dental or swallowing problems. Review of the revised care plan dated 2/2/22 revealed Resident #63 received anticoagulant	F 791	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. F791 Routine/Emergency Dental Srvcs in NFs Corrective action for resident(s) affected by the alleged deficient practice: Resident #63 had a dental follow-up on 3/18/2022 to have a broken tooth extracted. Corrective Action for Potentially Affected Residents. All residents have the potential for this practice. An audit was completed by the Director of Nursing and Administrator on 3/31/2022 to ensure all residents with dental procedures had follow-up with the	

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	345167	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 791	Continued From page 55 therapy with the risk for toxicity and abnormal bleeding. Interventions included: avoid activities that could result in injury. The physician's order dated 10/27/21 indicated the facility was to refer Resident #63 to a dentist as soon as possible due to a broken tooth in her right lower gum. The review of the dental examination dated 11/4/21 documented Resident #63 had upper dentures and a lower partial denture in her mouth, with no pain. The dentist recommended extracting the fractured tooth in-house and provided referral to the Social Worker. The dental examination documentation dated 12/8/21 revealed the Dentist was unable to perform the tooth extraction because the resident was still receiving the Eliquis (anticoagulant medication). Review of the clinical records revealed no documentation indicating the facility followed-up with the dentist when the resident's broken tooth was not extracted as scheduled. During an interview on 3/14/22 at 12:55 p.m., Resident #63 revealed her mouth was sore making it difficult for her to chew food due to a broken tooth in the lower part of her mouth. She stated that she was scheduled for an on-site examination with the dentist but was told by staff (after continuously asking when she would visit with the dentist) the facility forgot to "hold" her Eliquis for three days before the broken tooth could be extracted. On 3/17/22 at 10:24 a.m., the Social Worker	F 791	dentist/provider as scheduled. Three residents have been referred to an outside dentist by facility dentist. Awaiting acceptance by an outside dentist appointment arrangements. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The Social Worker was in serviced by the Administrator on 3/31/2022 regarding resident follow-up care for dental services and to print and bring all progress notes from dental services to morning meeting for review. The Administrator will be the backup to monitor dental service needs of the residents. Quality Assurance The Administrator or designee will complete Dental Procedure tracking form to determine all residents with dental procedures had follow-up with the dentist/provider as scheduled. Review will include 5 residents, 5 x weekly for 2 weeks then weekly for 3 months to ensure residents with dental procedures had follow-up with the dentist/provider as scheduled. Director of Nursing or designee will report all findings to the QA committee monthly. Any on-going monitoring will be deemed by the QA committee.	

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F 791	Continued From page 56 revealed the dentist contracted with the facility to provide dental exams visited every other month. She indicated she was aware the dentist did not extract Resident #63's tooth due to the resident was receiving Eliquis. During an interview on 3/17/22 at 11:11 a.m., the Administrator stated the dentist did not submit any pre-treatment orders for Resident #63 prior to his 12/8/21 visit for tooth extraction. She also revealed the dentist did not reschedule a follow-up visit with the resident. When asked, why did the facility not follow-up after reviewing the 12/8/21 dental visit documentation, the Administrator indicated the facility's unit managers reviewed all consult visits and followed-up with any issues or orders before the consult visit documentation was given to the facility's medical records. During an interview on 3/17/22 at 11:46 a.m., Unit Manager #2 stated prior to the dental visit on 12/8/21 the facility did not receive any pre-treatment orders concerning Resident #63. After reviewing the dentist's documentation dated 12/8/21, Unit Manager #2 noticed her initials were not on the document indicating she did not review the physical document. She revealed a couple days after the dentist's visit, the Social Worker informed her Resident #63's tooth extraction did not occur due to her medication, Eliquis was not stopped. The Unit Manager was unable to recall the resident complaining about a broken tooth when during her visits with the resident. The Unit Manager stated she did recall informing the hall nurses that the resident was unable to have her tooth extracted.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		4/4/22

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F 812	Continued From page 57 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 and staff interviews, the facility failed to ensure the food items stored in the snack/nourishment refrigerator in 1 of 2 residents' snack/nourishment rooms was maintained with food/beverage items that were dated and labeled with the residents' names and room numbers. Findings included: During an observation of Nourishment Room #1 on 3/15/22 at 1:45 p.m., the refrigerator contained the following items that were not dated or labeled with residents' names and room numbers: 1-16 oz (ounce) bottle of soda stored on the shelf of	F 812	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. F812__ Food Procurement, Store, Prepare, Serve-Sanitary Corrective action for affected residents On 3/16/2022, Nutritional supplements	

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F 812	Continued From page 58 the door; and 2-opened cardboard cases of single-serve nutritional supplement beverages (8oz sealed bottles). There were no residents' names on the cases or the bottles. Also, there were multiple beverages labeled with initials only which the Administrator was able to identify as the names of residents of the facility. A follow-up observation of the refrigerator in Nourishment Room #1 was conducted with the Dietary Manager (DM) on 3/16/22 at 1:40 p.m. There were 52 (8oz) sealed bottles of nutritional supplement beverages in the refrigerator that were not dated and labeled with residents' names. The DM revealed the nutritional supplement beverages were not purchased by the facility's dietary department. On 3/16/22 at 1:43 p.m., Housekeeper #1 revealed that the day before she was instructed to remove the cardboard cases from the refrigerator and place the 52 bottles on the shelves in the refrigerator. She indicated there were no residents' names on the boxes or on any of the bottles of the nutritional supplements. She stated that she assumed the dietary department had purchased the 52 bottles of the nutritional supplement. On 3/16/22 at 1:45 p.m., the Administrator stated that she did not know who the 52 bottles of the nutrition supplement belonged but would investigate.	F 812	noted to be unlabeled and undated were discarded from Nourishment Room #1 refrigerator by the Assistant Housekeeping Supervisor. Corrective Action for Potentially Affected Residents. All current residents have the potential to be affected by the alleged deficient practice. On 3/18/2022, the Administrator completed 100% inspection of all nourishment rooms, facility kitchen pantry, and refrigerators to ensure any food items/supplements stored in the snack/nourishment refrigerator were dated and labeled with the resident□s name and room number. Any items noted unlabeled or undated were discarded. Systemic Changes On 3/22/2022, the Administrator began In-service education to all full time, part time, and as needed dietary and clinical staff on checking for and discarding expired supplements and all food items must be stored, dated and discarded per NC State Regulations and Food Safety, Food Storage Policy reviewed. The Director of Nursing will ensure that any 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 dietary and clinical staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 4/4/2022 will not be allowed to	

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F 812	Continued From page 59	F 812	work until training has been completed. Quality Assurance The Dietary Manager or designee will monitor food storage 5 x weekly x 2 weeks then weekly x3 months using the Dietary QA Audit Tool. Monitoring will include auditing all nourishment rooms in which food is stored. 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 Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager	