STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 4/25/22 through 4/28/22. The facility was found in compliance with the requirement CFR 483.72, Emergency Preparedness. Event ID# HDUX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted 4/25/22 through 4/28/22. Four of eleven complaint allegations were substantiated resulting in federal citations: NC00186786, NC00188337 and NC00185414. See Event #HDUX11.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		5/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2022

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F 561	Continued From page 1 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to honor a resident's choice related to showers (Resident #10) for 1 of 2 residents reviewed for choices. The findings included: Resident #10 was originally admitted to the facility on 5/11/21 with diagnoses that included congestive heart failure (CHF), diabetes type 2 and muscle weakness. An annual Minimum Data Set (MDS) assessment dated 4/5/22 indicated Resident #10 was cognitively intact, was dependent on staff for all transfers and required extensive assistance with bathing. A review of Resident #10's active care plan, last reviewed 4/23/22, included a focus area for decreased ability to perform Activities of Daily Living (ADLs) related to weakness and impaired mobility. A review of Resident #10's nursing progress notes from 1/1/22 to 4/27/22 revealed no refusals of showers documented. A review of the "Station 1 Shower Schedule" forms dated 3/1/22 to 4/22/22 indicated Resident	F 561	1. Resident #10 is a current Resident of the Facility and is receiving showers at her request, confirmed by Resident interview and record review, Care Plan updated to reflect Resident□s choice for care. 2. All Residents who require assistance with showering have the potential to be affected. A thirty-day lookback audit will be completed by the Nursing Leadership Team for the dates 4/16/2022 to 5/16/2022 for all Residents or Resident Representatives to confirm shower days/schedule, if the Resident is receiving their showers, and any action taken if issues are noted. Audit was completed with no issues identified with shower schedules. 3. Education to be completed by 5/20/2022 by the Director of Nursing or designee for Licensed Nurses and C.N.A. (Full-Time, Part-Time, PRN and Agency) on all shifts and weekends, regarding shower schedules. Education to include offering showers to each Resident on their scheduled shower days and the process for refusals of showers. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and	

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F 561	Continued From page 2 #10 was to receive a shower every Tuesday and Friday on first shift (7:00 AM to 3:00 PM). The forms revealed no shower was documented as provided, instead the forms indicated a bed bath was provided or the entry was blank. There was one refusal of a shower documented on 4/22/22 where a bed bath was provided. On 4/25/22 at 2:54 PM, an interview occurred with Resident #10 who stated she was scheduled to receive showers on Tuesday and Fridays during the first shift but normally only received a shower on Tuesday. She explained a mechanical lift was required for all transfers and instead of a shower on Friday she received a bed bath, stating the staff told her it was because they were short staffed. Resident #10 stated she wanted to receive showers twice a week as scheduled because it helped with the pain in her shoulders and legs. Resident #10 was clean and free from odors at the time of the interview. An interview occurred with Nurse Aide (NA) #2 on 4/27/22 at 2:36 PM. She was familiar with Resident #10 and was often assigned to care for her on Fridays. NA #2 reviewed Resident #10's shower form which indicated she had provided a bed bath on 3/18/22 and left the form blank on 4/1/22. She was unable to recall whether a shower or bed bath was provided on 4/1/22 and added if she wasn't able to find someone to help with the mechanical lift transfer to the shower chair she would just provide a bed bath to Resident #10. NA #4 was assigned to Resident #10 on 4/15/22 and 4/22/22 and had marked a bed bath was provided, instead of a shower. NA #4 was unable to be interviewed.	F 561	Annual Education. 4. Shower Sheets will be reviewed by the Unit Managers three times weekly for four weeks to monitor for compliance to shower schedule and any refusals of showers/care. Any discrepancies will be addressed in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 561	Continued From page 3 The Director of Nursing (DON) was interviewed on 4/28/22 at 1:40 PM and stated she expected Resident #10's showers to be offered and provided on her scheduled days. If a resident refused a shower there should be documentation on both the NA documentation as well as the progress notes. The DON indicated new processes were being put into place to ensure showers were provided as scheduled and documentation accurate.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		5/20/22

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F 580	Continued From page 4 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident, staff, Consultant Pharmacist, Nurse Practitioner (NP), Medical Director interviews (MD) and record review the facility failed to notify the medical provider of missed administrations of prescribed medication (Resident #40). This was for 1 of 3 residents reviewed for notification. The findings included: Resident #40 was admitted on 7/16/22 with cumulative diagnosis of Paroxysmal (a sudden attack, increase or recurrence of a symptom or a disease) Atrial Fibrillation (A. Fib.), Congestive Heart Failure (CHF), Coronary Artery Disease, Cardiac Pacemaker, Cardiomyopathy,	F 580	1. Resident #40 is a current Resident of the Facility and is receiving his prescribed anticoagulant as ordered. Physician was notified on 4/26/2022, by the Unit Manager, of resident missing four doses of prescribed anticoagulant medication, MD had no recommended changes in response. 2. All Residents with orders for anticoagulants have the potential to be affected. A thirty-day lookback audit will be completed by the Nursing Leadership Team for the dates 4/16/2022 to 5/16/2022 for all current Residents	

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F 580	Continued From page 5 Hyperlipidemia (HLD) Peripheral Vascular Disease (PVD) with a history of a Deep Vein Thrombosis (DVT), left Above the Knee Amputation (left AKA) and right Below the Knee Amputation (Right BKA). He was readmitted on 2/4/22 with a right AKA. Resident #40's readmission orders included an order dated 2/5/22 for Pradaxa (anticoagulant) 150 milligrams (mg) 1 tablet twice a day for Paroxysmal A. fib. An interview was completed on 4/25/22 at 11:00 with Resident #40. He stated he recently had missed 4 doses of his prescribed Pradaxa. Resident #40 stated he had four Myocardial Infarction's (MI) in 2004, A. Fib., a pacemaker and DVT's in the past. He stated it concerned him and had asked Nurse #1 if the Pradaxa had been ordered. He stated she stated it had been ordered and there was no backup Pradaxa doses in the pyxis (an onsite automatized medication dispensing system cabinet). Resident #40 stated he had also discussed his concerns with Unit Manager (UM) #1 but was uncertain if the NP or MD were notified. Review of Resident #40's April 2022 Medication Administration Record (MAR) indicated Nurse #1 had worked on 4/20/22 and 4/21/22 with Resident #40 and administered both scheduled doses of Pradaxa. The MAR indicated he did not receive his 9:00 AM and 5:00 PM doses of Pradaxa on 4/22/22 and 4/23/22 (4 missed doses over the course of 48 hours). The MAR referred the reader to the nursing notes: Review of the nursing note dated 4/22/22 at 10:37 AM read awaiting Pradaxa from the pharmacy. The note was documented by Nurse # 1.	F 580	medication dose administration, for MD notification of any missed doses, and any action taken if issues are noted. Audit completed with no missed doses noted. 3. Education to be completed by the Director of Nursing or designee for all Nursing Staff (Full-Time, Part-Time, PRN and Agency) on all shifts and weekends, regarding Notifying the MD of Missed Medications/Medications not available at time of administration. Education to include procedures that if/when a Resident misses a Medication Dose, notifying the MD of the missed dose/medication, and documentation in PCC. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers will review Administration of anticoagulants five times a week for four weeks to monitor for proper administration. Any issues or discrepancies will be addressed in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 580	Continued From page 6	F 580		

Review of the nursing note dated 4/22/22 at 8:48 PM read awaiting Pradaxa from the pharmacy. The note was documented by Nurse #2.
Review of the nursing note dated 4/23/22 at 12:17 PM read the Pradaxa was not available and had been ordered. This note was documented by Nurse #3.
Review of the nursing note dated 4/23/22 at 5:59 PM read the Pradaxa had not arrived. It was scheduled to arrive this evening. This note was documented by Nurse #3.

There was no documented evidence that the NP or MD were ever notified of the missed doses of Resident #40's Pradaxa.

An interview was completed on 4/26/22 at 3:17 PM with Nurse #1. She stated she administered Resident #40's last available dose of Pradaxa on 4/21/22 at 5:00 PM. Nurse #1 stated she assumed the Pradaxa would be delivered in time for his 4/22/22 morning dose. She stated she checked the pyxis on 4/22/22 but there was no Pradaxa on the supply list so thought she called the pharmacy to reorder his Pradaxa, but she did not order it Stat (without delay). Nurse #1 stated she did not notify the NP or MD. Nurse #1 stated she thought she made UM #1 was made aware.

An interview was completed on 4/27/22 at 9:20 AM with UM #1. She stated when Resident #40's Pradaxa was reordered on 4/22/22, it should have been reordered Stat. She confirmed the Pradaxa was not in the pyxis. UM #1 stated she thought she notified the NP that Resident #40's Pradaxa was not available for administration.

A telephone interview was conducted on 4/28/22 at 6:25 AM with Nurse #2 who was assigned

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F 580	Continued From page 7	F 580		

Resident #40 on 4/22/22 on second shift. She stated when she became aware Pradaxa did not arrive in the afternoon pharmacy delivery, she did not notify the NP or MD that Resident #40 missed his 5:00 PM dose on 4/22/22.

A telephone interview was completed on 4/27/22 at 2:54 PM with Nurse #3 who worked with Resident #40 at the time his Pradaxa doses were scheduled to be given on 4/23/22 at 9:00 AM and 5:00 PM. Nurse #3 stated she asked Nurse #4 to check the pyxis and call the pharmacy to order the Pradaxa. Nurse #3 stated she did not notify the NP or MD about Resident #40's missing his Pradaxa doses.

A telephone interview was completed on 4/27/22 at 3:10 PM with Nurse #4. She stated she was helping out Nurse #3 and called the pharmacy on 4/23/22 about Resident #40's missing Pradaxa. She stated she did not order the Pradaxa Stat. She stated she did not notify the NP or MD about his missed doses of Pradaxa because she assumed Nurse #3 did.

A telephone interview was completed on 4/27/22 at 4:55 PM with Nurse #5. She stated anytime a resident missed a medication dose especially if the medication was an anticoagulant, the NP or MD must be notified in order to ask for an order and increased monitoring of the resident until any new orders were received.

A telephone interview was conducted on 4/28/22 at 11:58 AM with the MD. He stated he was not aware that the Resident #40 had missed 2 days of his Pradaxa. He stated the facility should have first contacted the NP then him if the NP did not respond.

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F 580	Continued From page 8 A telephone interview was completed on 4/28/22 at 12:11 PM with the NP. She stated she did not receive any calls from the facility on 4/22/22 and 4/23/22 regarding Resident #40's missed doses of his Pradaxa. The NP stated she would expect to be notified immediately and the facility increase monitoring of Resident #40 for complications. An interview was completed on 4/28/22 at 1:35 Pm with the DON. She stated she expected to nurses to notify the NP or MD regarding Resident #40's missed doses of Pradaxa.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		5/20/22

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F 584	Continued From page 9 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with resident and staff. The facility failed to provide adequate lighting for 1 of 1 resident (Resident #7) reviewed for environment. The findings included: Resident #7 was admitted to the facility on 3/26/2021. Resident #7's annual Minimum Data Set (MDS) dated 4/1/2022 indicated he was cognitively intact and had impaired vision. Resident #7 was independent with ambulation on and off the unit during the assessment period. The comprehensive care plan for Resident #7 was last reviewed on 4/15/2022 and contained a focus for risk of falls.	F 584	1. Resident #7 is a current Resident of the Facility and has had the light in his room replaced by the Maintenance Director on 4/28/2022. 2. All Residents have the potential to be affected. Maintenance Director or designee completed an audit on 5/16/2022 of all Resident Rooms to ensure that all lights are in working order. Any discrepancies were corrected in the moment. Maintenance Director found one additional Resident Room light out which was corrected on 5/16/2022. No other issues were identified. 3. Education to be completed by the Administrator or designee for all staff (Full-Time, Part-Time, PRN and Agency) on all shifts and weekends, regarding maintaining a home-like environment. Education to include the need to provide	

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F 584	Continued From page 10 On 4/25/2022 at 11:34 PM an observation and an interview was conducted with Resident #7. The resident was observed standing in the door of his room. The light in the resident's room was not on. The room was very dim with only light from the windows. When asked about the light in his room, Resident #7 stated the light was not working. He stated he made Nurse #10 aware. On 4/26/2022 at 2:30 PM a wound care observation was conducted for Resident # 7. Nurse #10 stated the resident's light was not working. Nurse #10 turned on the resident's bathroom light to provide adequate lighting for wound care. On 4/27/2022 at 8:19 AM during an observation of medication administration by Nurse #10, Resident #7's room light was not on, when writer asked about his room light, Resident #7 stated the light was not working. 4/28/2021 at 9:30 AM an interview was conducted with Resident #7. He stated his room light was not in working order. The light had been out since Monday, (4/25/22), and no one had come to repair the light. An interview was conducted with Nurse #10 on 4/28/2022 at 9:31 AM. She stated she became aware Resident #7's light was not working on Tuesday 4/26/2022 during wound care and forgot to make maintenance aware the light was not working.	F 584	adequate lighting to Residents, the process to report Maintenance Issues as they arise through Work Orders, and conducting proper follow-up to ensure the issue is resolved. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Maintenance Director or designee to audit five Resident Rooms weekly for four weeks to ensure that all lights are functioning properly. Any issues identified will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Maintenance Director monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		5/20/22

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The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

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F 636	Continued From page 12 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete an admission comprehensive Minimum Data Set (MDS) for 1 of 16 (Resident #247) reviewed for Resident Comprehensive Assessments. The findings include: Resident #247 was admitted to the facility on 4/11/2022 with diagnoses that included dementia. On 4/27/2022 Resident #247's admission comprehensive assessment with an Assessment Reference Date of 4/14/2022 was observed in the electronic medical record as "in progress" and not completed. An interview was completed with the MDS nurse on 4/27/2022 at 10:29AM. She stated Resident	F 636	1. Resident #247 is a current Resident of the Facility and has had his Admission Comprehensive Assessment completed by the MDS Nurse on 4/28/2022. 2. All Residents who have admitted have the potential to be affected. The Regional MDS Nurse to review all Admissions and Readmissions for the past thirty days for the dates 4/16/2022 to 5/16/2022 to ensure that Admission Comprehensive Assessments have been completed. Any discrepancies will be corrected in the moment. Audit was completed for all Admission Comprehensive Assessments for both Admissions and Readmissions with all Admission Comprehensive Assessments completed. 3. Education to be completed by 5/16/2022 by the Regional MDS Nurse for	

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F 636	Continued From page 13 #247's admission MDS was late. She further stated she was the only MDS nurse, and she had responsibilities outside of MDS. She had not had time to complete the assessment. On 4/28/2022 at 2:15 PM an interview was conducted with the Administrator. He stated the assessment should have been completed within the required timeframe. He was not aware the assessment was not completed.	F 636	the MDS Nurse regarding the timely and accurate completion of MDS Assessments. Education to include that each MDS Assessment, Comprehensive Assessment, Quarterly, Entry, Re-Entry, and Discharge Assessment should be completed in a timely and accurate manner. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Director of Nursing or designee to audit five MDS Assessments weekly for four weeks to ensure that Assessments are completed timely and accurately. Any issues identified will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 640		5/20/22

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F 640	Continued From page 14 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 640	1. Resident #1 is no longer a Resident of	

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F 640	Continued From page 15 facility failed to complete and transmit discharge Minimum Data Set (MDS) assessments for 2 of 4 residents reviewed for discharge. (Resident #1 and Resident #149). The findings included: 1. Resident #1 was admitted to the facility on 10/13/21. She discharged on 11/2/21. On 4/26/22 Resident #1 ' s discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 11/2/21 was observed in the electronic medical record as "open" and not completed. An interview was conducted with the MDS (Minimum Data Set) Nurse on 4/26/22 at 2:26 PM who stated she was unsure the reason it was not completed. The MDS Nurse further stated her discharge assessment should have been completed by 11/16/21. An interview was conducted with the Administrator on 4/28/22 at 2:10 PM who stated the discharge assessment should have been completed within the required timeframes. He stated he was unsure why the assessment was not completed. 2. Resident #149 was admitted to the facility on 3/30/2022. He was discharged on 4/11/2022. On 4/27/2022 Resident #149's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 4/11/2022 was observed in the electronic medical record as "open" and not completed.	F 640	the Facility. Discharge Assessment for Resident #1 was completed on 4/26/2022 by the MDS Nurse. 2. All Residents that have discharged have the potential to be affected. The Regional MDS Nurse to review all discharges for the past thirty days for the dates 4/16/2022 to 5/16/2022 to ensure that Discharge Assessments have been completed. Any discrepancies will be addressed in the moment. Audit was completed with all Discharge Assessments completed. 3. Education to be completed by 5/16/2022 by the Regional MDS Nurse for the MDS Nurse regarding the timely and accurate completion of MDS Assessments. Education to include that each MDS Assessment, Comprehensive Assessment, Quarterly, Entry, Re-Entry, and Discharge Assessment should be completed in a timely and accurate manner. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Director of Nursing or designee to audit five MDS Assessments weekly for four weeks to ensure that Assessments are completed timely and accurately. Any issues identified will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 640	Continued From page 16 An interview was conducted with the MDS nurse on 4/28/2022 at 12:45 PM who stated she had not completed the discharge MDS. The MDS nurse stated the assessment was late. It should have been completed on 4/25/2022. An interview was conducted with the Administrator on 4/28/2022 at 2:10 PM. He stated the discharge assessment should have been completed within required timeframe. He was not aware of a reason why the discharge assessment was not completed.	F 640		
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 record reviews, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Activities of Daily Living (Resident #75) and falls (Resident #94). This was for 2 of 18 residents reviewed. The findings included: 1. Resident #75 was admitted to the facility on 10/6/21 with diagnoses that included fracture to the right hip, muscle weakness and spondylolisthesis of the cervical region (a spinal condition that causes pain). The quarterly Minimum Data Set (MDS) assessment dated 3/21/22 indicated Resident #75 had moderately impaired cognition. The	F 641	1. Resident #75 is a current Resident of the Facility. MDS was corrected to properly reflect her ADL Care needs for Resident # 75 on 4/28/2022 by the MDS Nurse. Resident #94 is a current Resident of the Facility. MDS was updated for Resident # 94 on 4/27/2022 by the MDS Nurse, to reflect his fall on 3/31/2022. 2. The Regional MDS Nurse to complete a thirty-day lookback audit for all MDS Assessments to ensure that care needs and falls have been properly recorded on the MDS Assessment for the dates 4/16/2022 to 5/16/2022. Any deviations will be addressed in the moment. Audit was completed and showed no further issues with documentation of care needs	5/20/22

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F 641	Continued From page 17 MDS noted eating, dressing, toileting, personal hygiene, and bed mobility had only occurred once or twice during the seven day look back period. The assessment further noted Resident #75 was dependent on staff for bathing, had limited range of motion to one lower extremity and was always incontinent of bowel and bladder. Resident #75's active care plan, last reviewed 4/4/22, included a focus area for requiring assistance with ADL care related to a right hip fracture. A review of Resident #75's medical record from 1/1/22 through 4/27/22 revealed she required assistance with Activities of Daily Living (ADL's) such as dressing, toileting, personal hygiene and bed mobility. Furthermore, the medical record indicated Resident #75 consumed three meals a day with setup assistance from staff. On 4/25/22 at 2:50 PM, an interview occurred with Resident #75. She explained staff assisted with all her ADL's and she required setup assistance for meals three times a day. Nurse Aide (NA) #1 was interviewed on 4/27/22 at 1:45 PM and stated Resident #75 received setup assistance with meals and required extensive assistance with bed mobility, dressing toileting and personal hygiene tasks. An interview occurred with the MDS Nurse on 4/28/22 at 8:45 AM. She reviewed the 3/21/22 MDS assessment and verified the eating, dressing, toileting, personal hygiene, and bed mobility tasks were marked as activity occurred only once or twice during the seven day look back period. She explained the ADL portion of the	F 641	or falls. 3. Education to be completed by 5/16/2022 by the Regional MDS Nurse for the MDS Nurse regarding the timely and accurate completion of MDS Assessments. Education to include that each MDS Assessment, Comprehensive Assessment, Quarterly, Entry, Re-Entry, and Discharge Assessment should be completed in a timely and accurate manner. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Director of Nursing or designee to audit five MDS Assessments weekly for four weeks to ensure that Assessments are completed timely and accurately. Any issues identified will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 641	Continued From page 18 assessment was coded based on the ADL charting completed by the NA's but should have been coded as what the resident required whether it was set up, limited or extensive assistance as these tasks should have occurred daily. The MDS nurse further stated she didn't always talk to the residents or staff when coding the ADL portion of the assessment. On 4/28/22 at 1:40 PM, the Director of Nursing and Administrator were interviewed and stated it was their expectation for the MDS to coded accurately for Resident #75's ADL assistance needs. 2. Resident #94 was admitted to the facility on 3/30/22 with diagnoses that included hypertension and unsteadiness on his feet. Review of Resident #94 ' s medical record revealed a fall report dated 3/31/22 with no injury. Resident #94 ' s comprehensive Minimum Data Set assessment with a date of 4/6/22 revealed he was not coded for falls. An interview was conducted with the MDS (Minimum Data Set) Nurse on 4/26/22 at 2:26 PM who stated she was not aware Resident #94 had a fall. She reported the fall was not clearly documented in the progress notes so she would not have coded it. An interview was conducted with the Administrator on 4/28/22 at 2:10 PM who stated Resident #94 had a fall and it should have been coded on Resident #94 ' s assessment.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		5/20/22

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F 655	Continued From page 19	F 655		

§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.

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F 655	Continued From page 20 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete or formulate a baseline care plan within 48 hours (Resident #297) and failed to provide a summary of the baseline care plans to residents or their representatives (Resident #297, Resident #298, and Resident #93) for 3 of 3 residents reviewed for baseline care plans. The findings included: 1. Resident #297 was admitted to the facility on 4/21/22 with diagnoses that included dementia and heart disease. Review of Resident #297's care plan revealed a focus area for advanced directives that was initiated on 4/21/22. Other focus areas of the care plan were initiated on 4/24/22. An interview was conducted with the MDS Nurse on 4/26/22 at 2:26 PM who stated Resident #297's baseline care plan was initiated on 4/21/22. She stated the baseline care plan should address physician orders, dietary orders, therapy orders and social services orders. The MDS nurse stated she was unsure why the baseline care plan was not completed within 48 hours. The MDS nurse stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives.	F 655	1. Resident #297 is no longer a Resident of the Facility, her Baseline Care Plan has been completed and a copy of the Baseline Care Plan has been mailed to the Resident/Resident Representative. Resident #298 is a current Resident of the Facility; a copy of the Baseline Care Plan has been provided to the Resident/Resident Representative. Resident #93 is no longer a Resident of the Facility, a copy of the Baseline Care Plan has been mailed to the Resident/Resident Representative. 2. All Residents have the potential to be affected. The Regional MDS Nurse to complete a thirty-day lookback audit for all new admissions for the dates 4/16/2022 to 5/16/2022 to ensure that Baseline Care Plans have been completed in a timely manner. Additionally, a copy of the Baseline Care Plan for all Residents has been mailed to the Resident/Resident Representative. Audit was completed and showed no further issues with Baseline Care Plans being completed in a timely manner. 3. Education to be completed by 5/16/2022 by the Director of Nursing or designee for the MDS Nurse regarding providing a written copy of Baseline Care Plan to the Resident/Resident Representative. Education to include that	

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F 655	Continued From page 21 During a second interview with the MDS Nurse on 4/26/22 at 3:10 PM she stated summaries of the baseline care plans were not given to residents or their representatives. She reported if a resident or their representative would like a summary of their care plan, they would have to contact medical records. An interview was conducted with the facility social worker 4/27/22 at 10:05 AM on who stated baseline care plans would have to be requested from medical records. During an interview with the Medical Records Coordinator on 4/28/22 at 10:55 AM she stated she has not received a request for baseline care plans from Resident #297 or her family. During an interview with the Administrator on 4/28/22 at 2:10 PM he stated the baseline care plan should have been completed within 48 hours of Resident #297's admission. The Administrator further reported if residents or their representatives would like baseline care plan summaries, they would have to request them from medical records. 2. Resident #298 was admitted to the facility on 4/20/22 with diagnoses that included chronic obstructive pulmonary disease and hypertension. The medical record revealed no baseline care plan summary provided to the resident or resident responsible party. An interview with Resident #298's responsible party on 4/26/22 at 9:20 AM revealed no summary of Resident #298's baseline care plan	F 655	the written Baseline Care Plan should be completed within 48 hours post admission and include the initial goals of the Resident, a summary of the Resident□s Medications and Dietary instructions, any services and treatments to be administered by the Facility and personnel acting on behalf of the facility, any updated information based on the details of the Comprehensive Care Plan as necessary, and to provide a Written Care Plan at the Resident□s 72 Hour Post-Admission Conference. 4. Director of Nursing or designee to audit all new admissions weekly for four weeks and randomly thereafter, to ensure that Baseline Care Plans are completed timely and accurately. Any issues identified will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 655	Continued From page 22	F 655		

was provided.

An interview was conducted with the MDS Nurse on 4/26/22 at 2:26 PM who stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives.

During a second interview with the MDS Nurse on 4/26/22 at 3:10 PM she stated summaries of the baseline care plans were not given to residents or their representatives. She reported if a resident or their representative would like a summary of their care plan, they would have to contact medical records.

An interview was conducted with the facility social worker 4/27/22 at 10:05 AM on who stated baseline care plans would have to be requested from medical records.

During an interview with the Medical Records Coordinator on 4/28/22 at 10:55 AM she stated she has not received a request for baseline care plans from Resident #298 or her representative.

During an interview with the Administrator on 4/28/22 at 2:10 PM he reported if residents or their representatives would like baseline care plan summaries, they would have to request them from medical records.

3. Resident #93 was admitted to the facility on 3/30/22 with diagnoses that included dementia and depression.

Resident #93 was unavailable for an interview.

An interview was conducted with the MDS Nurse

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 23 on 4/26/22 at 2:26 PM who stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives. During a second interview with the MDS Nurse on 4/26/22 at 3:10 PM she stated summaries of the baseline care plans were not given to residents or their representatives. She reported if a resident or their representative would like a summary of their care plan, they would have to contact medical records. An interview was conducted with the facility social worker 4/27/22 at 10:05 AM on who stated baseline care plans would have to be requested from medical records. During an interview with the Medical Records Coordinator on 4/28/22 at 10:55 AM she stated she has not received a request for baseline care plans from Resident #298 or her representative. During an interview with the Administrator on 4/28/22 at 2:10 PM he reported if residents or their representatives would like baseline care plan summaries, they would have to request them from medical records.	F 655		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident	F 677	1. Residents #58, # 75, # 86, and # 247	5/20/22

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F 677	Continued From page 24 and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #58, #75, #86 and #247) for 4 of 7 residents reviewed for Activities of Daily Living (ADL's). The findings included: 1) Resident #58 was admitted to the facility on 4/15/21 with diagnoses that included vascular dementia, muscle weakness, and aphasia (a condition that affects your ability to communicate) following a stroke. A quarterly Minimum Data Set (MDS) assessment dated 3/4/22 indicated Resident #58 had moderately impaired cognition and had no behaviors or refusal of care. She required limited assistance with personal hygiene and bathing tasks and was coded with limited range of motion to one upper extremity. A review of Resident #58's active care plan, last reviewed on 3/18/22, included a focus area for decreased ability to perform ADLs related to vascular dementia with behavioral disturbance and right sided upper extremity functional limitations. A review of Resident #58's nursing progress notes from 1/1/22 to 4/27/22 revealed no refusals of nail care documented. On 4/25/22 at 10:48 AM, Resident #58 was observed while sitting in her recliner chair. She was noted to have long fingernails to the right hand and indicated with gestures, they rubbed her palm due to limited range of motion to that hand. Fingernails to the left hand were of varying lengths, from short to long, crooked cuts and	F 677	are current Residents of the Facility, nail care has been provided for these residents. 2. All Residents have the potential to be affected. Unit Managers completed an audit, on 5/16/2022 of all current Residents for their nail care needs to ensure all nail care needs have been met. Audit completed with no additional Residents noted to need nail care. 3. Education to be completed by the Director of Nursing or designee for all C.N.A.s (Full-Time, Part-Time, PRN and Agency) on all shifts and the weekends, regarding providing Nail Care. Education to include the need to provide Nail Care with ADLs/bathing/grooming daily and as need, and the documentation of Nail Care by the C.N.A. as the task is completed. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers will audit ten Residents weekly for four weeks, and randomly thereafter to ensure that nails are clean and at length of the Resident□s preference. Any deviations will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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jagged edges as well as a dark substance under them.

Resident #58 was observed on 4/26/22 at 2:18 PM while sitting up in her recliner chair. Her nails to both hands remained unchanged from previous observations.

An observation occurred of Resident #58 on 4/27/22 at 9:25 AM while she was in her recliner chair. Fingernails to the right hand remained long and fingernails to the left hand remained with varying lengths, some with jagged edges and dark substance under them.

On 4/27/22 at 10:30 AM, an interview was completed with Nurse Aide (NA) #2 and #3, who were both familiar with Resident #58. They explained Resident #58 was very independent with her care but were aware Resident #58 had limited mobility to her right hand and felt it would be difficult for her to complete her own nail care. The NA's stated they had not provided care to her fingernails and were unaware her nails needed attention. The NA's stated nail care was provided when needed.

An interview occurred with Unit Manager #2 on 4/27/22 at 2:42 PM who was familiar with Resident #58. She indicated Resident #58 would refuse showers and bathing assistance from time to time but was not aware of any refusals for nail care. She explained resident would not be able to manage her own fingernails due to limited mobility in the right hand and weakness to the left hand. Unit Manager #2 was unaware Resident #58 needed nail care. She added nail care should be completed as needed during personal care assistance.

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The Director of Nursing (DON) was interviewed on 4/28/22 at 1:40 PM and stated she would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse/Unit Manager to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #58 as there was no documentation to show this had or had not been completed or attempted.

2) Resident #75 was admitted to the facility on 10/6/21 with diagnoses that included muscle weakness, osteoarthritis, and spondylolisthesis of the neck (a spinal condition that causes pain).

A quarterly Minimum Data Set (MDS) assessment dated 3/21/22 indicated Resident #75 had moderately impaired cognition and had no behaviors or refusal of care. She required limited assistance with personal hygiene and bathing tasks.

A review of Resident #75's active care plan, last reviewed on 4/4/22, included a focus area for required assistance for ADL care related to right hip fracture.

A review of Resident #75's nursing progress notes from 1/1/22 to 4/27/22 revealed no refusals of nail care documented.

On 4/25/22 at 2:50 PM, Resident #75 was observed while sitting up in bed watching TV. She was noted to have long fingernails to both hands with a dark substance under them. Resident #75

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stated, "they are longer than I like to wear them. Do I need to pay to have them cut?"

An observation occurred of Resident #75 on 4/27/22 at 9:22 AM while she was lying in bed watching TV. Fingernails to both hands remained long with a dark substance under them.

On 4/27/22 at 10:30 AM, an interview was completed with Nurse Aide (NA) #2 and #3, who explained nail care was completed as needed during personal care and bathing tasks.

NA #1 was interviewed on 4/27/22 at 1:45 PM and indicated she was assigned to Resident #75. She stated she had not provided nail care nor was she aware it was needed for Resident #75.

An interview occurred with Unit Manager #2 on 4/27/22 at 2:42 PM who was familiar with Resident #75 and was unaware nail care was needed. She added nail care should be completed when needed during personal care assistance.

The Director of Nursing (DON) was interviewed on 4/28/22 at 1:40 PM and stated she would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse/Unit Manager to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #75 as there was no documentation to show this had or had not been completed or attempted.

3) Resident #86 was admitted to the facility on

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3/24/21 with diagnoses that included dementia, history of a stroke, contracture of the right hand and diabetes type 2.

A quarterly Minimum Data Set (MDS) assessment dated 3/23/22 indicated Resident #86 had moderately impaired cognition and had no behaviors or refusal of care. She required extensive assistance with personal hygiene and was coded with limited range of motion to one upper extremity.

A review of Resident #86's active care plan, last reviewed on 4/8/22, included a focus area for requiring assistance for ADL care related to history of mini-strokes and a stroke as well as paralysis to the right side.

A review of Resident #86's nursing progress notes from 1/1/22 to 4/27/22 revealed no refusals of nail care documented.

On 4/25/22 at 2:28 PM, Resident #86 was observed lying in bed. A contracture was present to the right hand with the appearance of a fist. Fingernails to the right hand were observed to be long with a small red indention to the palm of the right hand. The left-hand fingernails were long in length with a yellow and brown substance under them.

Resident #86 was observed on 4/26/22 at 2:30 PM while lying in bed. Her nails to both hands remained unchanged from previous observations.

An observation occurred of Resident #86 on 4/27/22 at 9:40 AM while she was lying in bed. Fingernails to the right hand remained long and fingernails to the left hand remained long with a

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yellow and brown substance under them.

On 4/27/22 at 10:30 AM, an interview was completed with Nurse Aide (NA) #3, who stated nail care was provided when needed during personal care and bathing tasks.

NA #2 was interviewed on 4/27/22 at 2:36 PM and indicated she was assigned to Resident #86. She observed the fingernails to Resident #86 and stated they needed trimming and had a substance under the left-hand nails. NA stated she was unaware of the need but would get them cleaned and let the nurse know they needed trimming since Resident #86 was a diabetic.

An interview occurred with Unit Manager #2 on 4/27/22 at 2:42 PM who was familiar with Resident #86 and stated she was unaware nail care was needed. Unit Manager #2 stated NAs could clean under a diabetic's fingernails, but nursing staff would need to trim them and was unable to state why this had not occurred.

The Director of Nursing (DON) was interviewed on 4/28/22 at 1:40 PM and stated she would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse/Unit Manager to be notified of the need. The DON was unable to explain why nail care had not occurred for Resident #86 as there was no documentation to show this had or had not been completed or attempted.

4. Resident #247 was admitted to the facility on 4/11/2022 with diagnoses that included dementia.

Resident #247's admission Minimum Data Set

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(MDS) was not completed.

The resident's baseline care plan, dated 4/11/2022, had a focus for assistance with activities of daily living related to weakness.

On 4/25/2022 at 11:48 AM Resident #247 was observed lying in bed. He had long fingernails with brown matter beneath them on both hands. When asked if he had nail care since he was admitted, the resident shook his head no.

Resident #247 was observed sitting in a wheelchair by the nurse station on 4/27/2022 at 10:00 AM. His fingernails were long with brown matter beneath the nails on both hands.

On 4/27/2022 at 10:15 AM an interview was conducted with nurse assistant (NA) #1. She stated nail care was typically provided on shower days if needed. When asked if she worked with Resident #247, she stated she had worked with him, but she was not assigned to him on 4/27/2022. The NA assigned to Resident #247 was NA #3.

An interview was conducted with NA#3 on 4/27/2022 at 10:20 AM. NA #3 observed Resident #247's nails and stated she had noticed his fingernails were long and sharp. She further stated nail care was typically provided on shower days. She was not sure when Resident #247 was scheduled for showers.

On 4/28/2022 at 2:15 PM an interview was conducted with the Director of Nursing (DON). She stated dependent residents should be provided nail care.

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F 684	Continued From page 31	F 684		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide non-pressure related wound care as ordered, resulting in 18 missed wound care treatments, for 1 of 2 residents (Resident #49) reviewed for wound care. The findings included: Resident #49 was admitted on 9/21/2021 with diagnoses that included diabetes. The resident's quarterly Minimum Data Set (MDS) dated 4/6/2022 indicated Resident #49 was cognitively intact without moods or behaviors and had functional hearing and vision. The MDS also indicated the resident had 1 stage four pressure injury that was present on admit, 2 unstageable pressure injuries that were present on admit, and one surgical wound during the assessment period. Resident #49's comprehensive care plan was last revised on 4/26/2022 and had a focus for actual skin breakdown (including wounds to hip, heel,	F 684	1. Resident #49 is a current Resident of the Facility. The wound order for Resident # 49 has been corrected to BID. Resident # 49 is receiving wound treatment per order. 2. All Residents with wounds have the potential to be affected. A thirty-day lookback audit was completed for the dates 4/16/2022 to 5/16/2022 on 5/16/2022 by the Nursing Leadership Team for all Residents with wound care orders to ensure proper transcription. Any issues or discrepancies identified will be addressed in the moment. Audit was completed and no other issues with order transcription were found. 3. Education to be provided by the Director of Nursing or designee for all Nursing Staff (Full-Time, Part-Time, PRN and Agency) on all shifts, regarding Wound Orders. Education to include that each Wound Order is noted in PCC upon receipt, ensuring that each Wound Order is followed/completed per MD Order, documentation of wounds including their	5/20/22

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F 684	Continued From page 32 elbow, and surgical wound to groin) related to impaired mobility and diabetes. Interventions included wound care as ordered. Resident #49's medical record revealed he was hospitalized from 3/24/2022 through 3/30/2022 for incision and drainage of perineal, scrotal, lower abdominal abscess and debridement of non-viable tissue with diagnosis of Fournier's gangrene (a form of necrotizing fasciitis, or flesh-eating bacterial infection, that has a high morbidity and mortality rate). The resident followed up with urology on 4/7/2022 for ongoing wound care and management of indwelling urinary catheter. Urology wound care orders dated 4/7/2022 read as follows; Replace packing in wound superior to penile stump and to the wound in left groin below scrotum (BID) twice daily. Pack with moist to dry kerlix twice daily. The urologist recommended a follow up appointment in 7 days. Urology follow up on 4/14/2022 addressed management of indwelling urinary catheter. There was no change in wound care orders for the 4/14/2022 visit. The resident was instructed to follow up with urology again in 14 days. Attempts to contact the urologist were not successful. Resident #49's April 2022 Treatment Administration Record (TAR) reveled an order dated 4/2/2022 that read as follows; Change packing to wound on right upper scrotum just right of penis shaft once daily with wet to dry kerlix dressing. Be sure to completely pack the wound by placing packing deeply. The TAR indicated the resident got wound care once daily.	F 684	improvement/worsening weekly in the Skin Assessment, notifying the MD of wounds, and documentation in PCC of notification or new orders obtained. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers will audit for new wound care orders five times a week for four weeks and then weekly thereafter to ensure proper transcription of wound care orders. Any discrepancies or issues will be corrected in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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On 4/26/2022 at 3:05pm wound care on Resident #49 was observed. Wound care was performed by Nurse #7 and Unit Manager #1. The wound was noted to have a strong and foul odor that permeated the room. There was a copious amount of purulent drainage observed on the old dressing. The old packing was removed, the wound bed was cleaned, and new wet to dry packing was placed and secured with foam pad. The resident did not express any pain during the wound care observation.

On 4/28/2022 at 10:24 AM an interview was conducted with Nurse #7. She stated the facility did not have a treatment nurse, so the nurse assigned to the resident performs wound care. She further stated she had provided wound care for Resident #7. She stated wound care was provided once daily. She stated she thought the wound was showing some improvement. She was not aware of the urology wound care order dated 4/7/2022 for wound care twice daily.

On 4/28/2022 at 12:00PM an interview was conducted with Unit Manger #1. She stated she assisted with wound care for Resident #49. She described the wound as complex and stated she felt the wound was not getting better, but it was not getting worse. She characterized the wound as stable. She further stated the urologist had been giving wound care orders. She viewed the order dated 4/7/2022 and stated she had never seen the order and therefore wound care was only being done once daily on the groin.

An interview was conducted with the Director of Nursing (DON) on 4/28/2022 at 9:41 AM. She reviewed the 4/7/2022 wound care order by

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F 684	Continued From page 34 urology and stated she had not seen the order before. She further stated when residents are seen by outside providers, written orders were provided and returned with the resident or orders were faxed to the facility. The orders are then put into the electronic medical record by either the unit nurses, the nurse manager, or herself. The DON stated she asked the unit nurses and unit mangers about the order, and they had no knowledge of the order. She was not sure who or how the order was received by the facility or how it got into the resident's electronic medical record. A phone interview was conducted with physician #2. He stated he recalled seeing the resident soon after his readmission on 3/30/2022 but he had not seen the wound since that time. He was not aware of the urology order to provide wound care twice daily. He could not say if the wound was getting better, worse, or if it was stable.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		5/20/22

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F 755	Continued From page 35 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to administer medications per physician's order for 1 of 7 residents (Resident # 92) whose medications were reviewed. The findings included: Resident #92 was admitted on 1/31/2020 with diagnoses that included anxiety disorder. Resident #92's significant change Minimum Data Set (MDS) dated 3/29/2022 indicated the resident was moderately cognitively impaired. She received antianxiety medication 5 out of 7 days during the assessment period. Resident #92's comprehensive care plan, last revised 4/12/2022, had a focus for distress and fluctuating mood swings related to her anxiety.	F 755	1. Resident #92 is a current Resident of the Facility. The alprazolam is currently in stock and being administered to Resident # 92 as ordered by the MD as of 3/30/2022. 2. All Residents with orders for anti-anxiety medications have the potential to be affected. A thirty-day lookback audit was completed by the Nursing Leadership Team for the dates 4/16/2022 to 5/16/2022 on 5/16/2022 for all Residents receiving anti-anxiety medications to ensure that all medications have been administered per MD orders. Any discrepancies or issues will be corrected in the moment. Audit completed with all anti-anxiety medications administered per MD orders. 3. Education to be provided by the Director of Nursing or designee for all Nursing Staff (Full-Time, Part-Time, PRN	

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F 755	Continued From page 36 A record review revealed an order for alprazolam (a medication for anxiety) 0.25mg by mouth twice daily with a start date of 9/16/2020 with no end date. Resident #92's Medication Administration Record (MAR) for March 2022 revealed the resident did not get the scheduled alprazolam on the following dates: 3/27/2022 Nurse #3 did not administer the 9:00 AM dose. 3/28/2022 Nurse #1 did not administer the 9:00 AM dose. 3/28/2022 Nurse#8 did not administer the 5:00 PM dose. 3/29/2022 Nurse #1 did not administer the 9:00 AM dose. On 4/27/2022 at 1:43 PM an interview was conducted with Nurse #3. She stated on 3/28/2022 at 5:00 PM the resident's alprazolam was not available to administer. She further stated the resident's medication was not in the facility. When asked about a backup supply, she stated the facility did have an Omnicell with back up medications but alprazolam 0 .25mg was not in the Omnicell. When asked if she made anyone aware the medication was not available, she stated she did not recall if she ordered the medication or if she notifed anyone. On 4/27/2022 at 1:57 PM an interview was conducted with Nurse #1. She stated she did work on the medication cart 3/28/2022 and 3/29/2022. She further stated she did not give Resident #92 her alprazolam because the medication was not available to give. The resident was out of the medication. When asked about back up medications, she stated	F 755	and Agency) on all shifts and the weekends, regarding administering medications as ordered. Education to include that all medications should be administered per MD order, that all medications should be ordered/reordered from the Pharmacy in a timely manner, procedure if a medication does not come in from the Pharmacy, and STAT/After Hours process for obtaining medications from Pharmacy. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers to audit anti-anxiety medications five times a week for four weeks then weekly thereafter for compliance with administration per MD orders. Any discrepancies or issues will be addressed in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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F 755	Continued From page 37	F 755		

alprazolam was not available in the Omnicell. When asked if she notified a provider the medication was not available, she stated she did not recall if she notified anyone, but she did order the medication from pharmacy.

On 4/27/2022 at 12:58 PM an interview was conducted with Nurse#8. She stated she did not give resident #92 alprazolam on 3/28/2022 because the medication was not available to give the resident. Nurse #8 stated she was an agency nurse and could not order medications from pharmacy. She further stated she made Unit Manager #1 aware the medication was not available.

On 4/27/2022 at 1:52 PM an interview was conducted with Unit Manager #1. She stated she did not recall Nurse #8 notifying her Resident #92 was out of alprazolam. She further stated there was a location in the Omnicell for alprazolam but there was none of the medication stocked in the Omnicell.

A phone interview was conducted with the Pharmacy Account Manager on 4/28/2022 at 10:45 AM. She stated Resident #92's alprazolam was ordered on 3/29/2022. The medication was delivered to the facility on 3/29/2022, the same day it was requested. The Pharmacy Account Manager stated if the facility runs out of a medication and the medication is not in the Omnicell, it can be ordered stat (immediately) and will get to the facility withing 2-3 hours typically.

An interview was conducted with the Director of Nursing on 4/28/2022 at 2:15 PM. She stated nurses working the medication carts should order the medication when it is low, so the medication

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F 755	Continued From page 38 does not run out. However, if the medication is not available, they should check the Omnicell for the medication. If the medication is not in the Omnicell, it can be ordered stat (immediately) from pharmacy. She further stated she expected resident to receive medications as ordered by the physician.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, Consultant Pharmacist, Pharmacy Account Manager, Nurse Practitioner (NP), Medical Director interviews (MD) and record review the facility failed to administer an anticoagulant (Blood Thinner) as ordered twice a day for 2 days for a total of 48 hours. This was for 1 (Resident #40) of 7 residents reviewed for medications. The findings included: Resident #40 was admitted on 7/16/22 with cumulative diagnosis of Paroxysmal (a sudden attack, increase or recurrence of a symptom or a disease) Atrial Fibrillation (A. Fib.), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), a Cardiac Pacemaker, Cardiomyopathy, Hyperlipidemia (HLD) Peripheral Vascular Disease (PVD) history of a Deep Vein Thrombosis (DVT), left Above the Knee Amputation (left AKA) and right Below the Knee Amputation (Right BKA). He was readmitted on 2/4/22 with a Right AKA.	F 760	1. Resident #40 is a current Resident of the Facility. Resident # 40 is receiving prescribed anticoagulant as ordered. 2. All Residents with orders to anticoagulants have the potential to be affected. A thirty-day lookback audit was completed by the Nursing Leadership Team for the dates 4/16/2022 to 5/16/2022 on 5/16/2022 for all current Resident medication dose administration, for MD notification of any missed doses, and any action taken of issues are noted. Audit completed with no missed doses noted. 3. Education to be completed by the Director of Nursing or designee for all Nursing Staff (Full-Time, Part-Time, PRN and Agency) on all shifts and the weekends, regarding Notifying the MD of Missed Medications. Education to include procedures that if/when a Resident misses a Medication Dose, notifying the MD of the missed dose/medication, and	5/20/22

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F 760	Continued From page 39 Resident #40's readmission orders included an order dated 2/5/22 for Pradaxa (anticoagulant) 150 milligrams (mg) 1 tablet twice a day for Paroxysmal A. fib. Resident #40's quarterly Minimum Data Set dated 2/11/22 indicated he was cognitively intact and he was coded as receiving and anticoagulant 7 days of 7 days for look back period of the assessment. Resident #40's comprehensive care plan included the following focuses both revised on 2/4/22: Resident #40 is at risk for injury or complications related to the use of anticoagulation therapy medication Pradaxa. Interventions included administering the anticoagulant as ordered and obtain vital signs as ordered. Resident #40 exhibits or is at risk for cardiovascular symptoms or complications related to chronic systolic heart failure, CAD, A. Fib., cardiomyopathy, the presence of a cardiac pacemaker, HLD, PVD and Hypertension (HTN). Interventions included administering his medications as order, assess for effectiveness, report abnormalities to the Physician and monitoring of his vital signs. An interview was completed on 4/25/22 at 11:00 with Resident #40. He stated he recently missed 4 doses of his prescribed Pradaxa. Resident #40 stated he had four Myocardial Infarction's (MI) in 2004, A. Fib., a pacemaker and DVT's in his past. He stated it concerned him and he asked Nurse #1 if the Pradaxa had been ordered. He stated she stated it had been ordered and there was no backup Pradaxa doses in the pyxis (an onsite automatized medication dispensing system cabinet). Resident #40 stated he had also discussed his concerns with Unit Manager (UM)	F 760	documentation in PCC. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers will review administration of anticoagulants five times a week for four weeks and weekly thereafter to monitor for proper administration. Any issues or discrepancies will be addressed in the moment. Results of this audit will be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	

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#1.

Review of the item list of back up medications in the pyxis did not include Pradaxa but did include Coumadin and Xarelto which are classified as anticoagulants.

Review of Resident #40's April 2022 Medication Administration Record (MAR) indicated Nurse #1 worked 4/20/22 and 4/21/22 with Resident #40 and administered both scheduled doses of Pradaxa ordered at 9:00 AM and 5:00 PM. The MAR indicated Resident #40 did not receive his scheduled 9:00 AM and 5:00 PM doses of Pradaxa on 4/22/22 and 4/23/22. The MAR referred the reader to the nursing notes:
Review of the nursing note dated 4/22/22 at 10:37 AM read awaiting Pradaxa from the pharmacy. The note was documented by Nurse # 1.
Review of the nursing note dated 4/22/22 at 8:48 PM read awaiting Pradaxa from the pharmacy. The note was documented by Nurse #2.
Review of the nursing note dated 4/23/22 at 12:17 PM read the Pradaxa was no available and had been ordered. This note was documented by Nurse #3.
Review of the nursing note dated 4/23/22 at 5:59 PM read the Pradaxa had not arrived. It was scheduled to arrive this evening. This note was documented by Nurse #3.

An interview was completed on 4/26/22 at 3:17 PM with Nurse #1. She confirmed she worked with Resident #40 on 4/20/21 and 4/21/22 during the time that both doses of his Pradaxa were administered and she administered Resident #40's last available dose of Pradaxa on 4/21/22 at 5:00 PM. Nurse #1 stated she assumed his Pradaxa would be in the 4/21/22 afternoon or

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midnight pharmacy delivery in time for Resident #40's next 4/22/22 morning dose. She stated she checked the pyxis on 4/22/22 but there was no Pradaxa on the supply list so she called the pharmacy to reorder his Pradaxa but she did not order it Stat (without delay). When asked what Pradaxa was prescribed for, she stated she did not know. Nurse #1 stated she thought she made UM #1 was made aware.

An interview was completed on 4/27/22 at 9:20 AM with UM #1 with the Director of Nursing (DON) present. UM #1 stated Nurse #1 notified her that she ordered Resident #40's Pradaxa on 4/22/22 and assumed she ordered it Stat. UM #1 confirmed the Pradaxa was not in the pyxis. She stated when Resident #40's Pradaxa came from the pharmacy, it was in a labeled plastic bag with each individual dose in a foil pack. She stated she did not think the pharmacy was sending enough doses but had not discussed it with the pharmacy. She stated she was under the impression that his Pradaxa was set up as an autofill medication for Resident #40 and that it would be available for administration on 4/22/22. UM #1 stated the facility did not have a local backup pharmacy. She stated the pharmacy provider was owned by a large pharmacy chain with no local pharmacy that would deliver to the facility. UM #1 stated the afternoon pharmacy delivery arrived between 4:00 PM and 5:00 PM and the midnight pharmacy delivery arrived between 2:00 AM and 3:00 AM. The DON stated she was under the impression that there was a local backup pharmacy that even if they didn't deliver, staff could go and pick it up. UM #1 stated there was not a local back up pharmacy and everything, even Stat orders, were done through the pharmacy provider.

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A telephone interview was conducted on 4/28/22 at 6:25 AM with Nurse #2 who was assigned Resident #40 on 4/22/22 on second shift. She recalled Resident #40's 5:00 PM dose of Pradaxa had not arrived yet from the pharmacy. Nurse #2 confirmed the afternoon pharmacy delivery arrived between 4:00 PM and 5:00 PM and the midnight pharmacy delivery arrived between 2:00 AM and 3:00 AM. Nurse #2 stated she was aware the Pradaxa did not arrive in the afternoon pharmacy delivery, so she assumed it would arrive in the 4/22/22 midnight pharmacy delivery.

A telephone interview was conducted on 4/27/22 at 2:48 PM with the facility's Consultant Pharmacist. She stated Resident #40's Pradaxa was not set up as an automatic refill but rather it was set up as "on demand." She explained when a medication is set up on demand, it was the responsibility of the facility to reorder the medication several days before running out. The Consultant Pharmacist's stated the Pradaxa should have been ordered Stat on 4/22/22. She stated she was able to read the communication from the facility to the pharmacy regarding Resident #40's Pradaxa and there was no documented evidence it was ordered on 4/22/22 but rather it was ordered on 4/23/22 however it was not ordered Stat.

An interview was completed on 4/27/22 at 10:15 AM with UM #2. She stated if a medication was not available, the procedure was to call the pharmacy and ask for the medication to be sent out in the next delivery but if the medication was an anticoagulant, it should be ordered Stat. She stated the pharmacy provider delivered daily in the afternoon and at midnight. UM #2 stated this

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past weekend, there was a medication ordered Stat for another resident and it arrived at the facility in a few hours. When asked if Pradaxa was in the backup pyxis, she stated she did not know.

A telephone interview was completed on 4/27/22 at 2:54 PM with Nurse #3 who worked with Resident #40 at the time his Pradaxa doses were scheduled to be given on 4/23/22 at 9:00 AM and 5:00 PM. Nurse #3 stated Saturday morning, she noticed he was missing his Pradaxa and first checked the pyxis but discovered Pradaxa was not on the medication supply list. She stated she then asked Nurse #4 to call the pharmacy to order Resident #40's Pradaxa. Nurse #3 stated she unsure if Nurse #4 ordered Resident #40's Pradaxa Stat because his Pradaxa had still not arrived in the afternoon delivery for his 5:00 PM dose. Nurse #3 stated she did not recall reporting to the oncoming nurse (Nurse #9) that Resident #40 missed both doses of his Pradaxa on 4/23/22.

A telephone interview was completed on 4/27/22 at 3:10 PM with Nurse #4. She stated she was helping out Nurse #3 and called the pharmacy on 4/23/22 about Resident #40's missing Pradaxa. She stated she did not order the Pradaxa Stat but assumed the Pradaxa would be delivered in the afternoon pharmacy delivery.

A telephone interview was conducted on 4/28/22 at 6:00 AM with Nurse #9. He stated he worked 3rd shift with Resident #40 on the night of 4/23/22 and it was not reported to him that Resident #40 missed both doses of Pradaxa on 4/23/22. Nurse #9 stated his 14 day supply arrived in the midnight delivery on 4/23/22.

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Review of the pharmacy of a form titled Proof of Delivery Shipment Details indicated a 14 day supply (28) tablets of Pradaxa was received by the facility on 4/23/22 at 12:33 AM.

A telephone interview was completed on 4/28/22 at 10:34 AM with the Pharmacy Account Manager. She confirmed that Pradaxa was not included in the onsite pyxis. She stated according to their pharmacy records, Resident #40's Pradaxa was ordered on 4/23/22 and was sent out in the midnight pharmacy delivery. She stated Resident #40's Pradaxa was set up as an "on demand" refill and the facility received a total of 28 tablets for 14 days then had to be reordered prior to running out of the medication. The Pharmacy Account Manager stated there were numerous delivery drivers and when a medication was ordered Stat but the facility had to contact the pharmacy by phone and convey that it was a Stat medication order. When the pharmacy was notified, the medication order was filled and then the closest delivery driver was dispatched to return to the pharmacy and pick up the Stat medication to be delivered to the facility next. She stated the normal turnaround time for a Stat order was within 2-3 hours maximum. She stated the contract between the pharmacy and the facility read that a Stat order must be delivered within 4 hours.

An observation of Resident #40's Pradaxa supply in the medication cart was completed on 4/28/22 at 11:20 AM with Nurse #1. A label was noted on the outside of a clear plastic bag with individual doses with the name Pradaxa on the top of a foil sealed packet. The label read it was prescribed for Resident #40 and was Pradaxa 150mg 1

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F 760	Continued From page 45 tablet twice a day. The label read it was filled last on 4/23/22 and may be refilled after 5/4/22. There was enough tablets to last until 5/7/22. A telephone interview was conducted on 4/28/22 at 11:58 AM with the MD. He described Resident #40 as a "medically complicated resident." He stated he was not concerned about Resident #40 missing 4 doses of his Pradaxa because his A. Fib was Paroxysmal (a sudden attack, increase or recurrence of a symptom or disease). He stated Pradaxa was not the most commonly prescribed anticoagulant and it had a fairly long half-life of around 12 hours. When questioned about the time frame of 48 hours that Resident #40 missed his Pradaxa medication, he stated there was no change in his condition to suggest an irregular heartbeat and Resident #40's vital signs remained stable. A telephone interview was completed on 4/28/22 at 12:11 PM with the NP. She stated Pradaxa was a medication that should always be administered as scheduled due to Resident #40's diagnosis of Paroxysmal A. Fib. She stated she expected the Pradaxa to be reordered before using the last dose but if that occurred, the Pradaxa would have to be ordered Stat. An interview was completed on 4/28/22 at 1:35 Pm with the DON. She stated she would defer her expectation about Resident #40's missed Pradaxa doses to the MD.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		5/20/22

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resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345277	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILL CENTER	400 VISION DRIVE ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 47 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews, the facility failed to have complete and accurate medical records in the areas of physician assessment (Resident #49) and in the area of administration of respiratory treatments (Resident #298) for 2 of 19 residents reviewed. The findings included: Resident #49 was admitted on 9/21/2021 with diagnoses that included diabetes. Resident #49's medical record revealed he was hospitalized from 3/24/2022 through 3/30/2022	F 842	1. Resident #49 is a current Resident of the Facility. Resident # 49 was seen by his Provider on 3/31/2022 and the progress note has been uploaded to his Medical Record. Resident #298 is a current Resident of the Facility. Resident # 298 continues with her BiPaP usage with no documentation issues noted. 2. All Residents with recent readmissions have the potential to be affected. A thirty-day lookback audit was completed by the Nursing Leadership Team for the dates 4/16/2022 to 5/16/2022 on 5/16/2022 for all readmissions to ensure	

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F 842	Continued From page 48 for incision and drainage of perineal, scrotal, lower abdominal abscess and debridement of non-viable tissue with diagnosis of Fournier's gangrene (a form of necrotizing fasciitis, or flesh-eating bacterial infection, that has a high morbidity and mortality rate). The resident's medical record did not contain documentation a physician or nurse practitioner had evaluated the resident after his readmission on 3/30/2022. An interview was conducted with the Director of Nursing on 4/28/2022 at 1:35 PM. She stated she could not find any documentation a physician or nurse practitioner had completed an assessment on Resident #49 since his readmission 3/30/2022. She further stated Physician #2 documented his visits on paper. He did not document his visits in the electronic medical record. She stated she could not find written documentation of a physician's visit since 3/30/2022. On 4/28/2022 at 2:15 PM an telephone interview was conducted with Physician #2. He stated he did see Resident #49 after his readmission to the facility on 3/30/2022. He further stated he was on his way to the airport and would fax or email a copy of the documentation to the facility. No documentation of a visit was provided by physician #2 or by the facility. 2. Resident #298 was admitted to the facility on 4/20/22 with diagnoses that included hypertension and chronic obstructive pulmonary disease. A physician's order dated 4/20/22 for Resident	F 842	timely follow-up by the Provider and documentation of their visit has been uploaded into PCC. All Residents with orders for a BiPaP have the potential to be affected. A thirty-day lookback audit was completed by the Nursing Leadership Team on 5/16/2022 for all Residents with orders for BiPaP to ensure that there are no issues with documentation of usage. Audit completed with no Residents missing a Provider visit. Audit completed with no Residents missing proper BiPaP documentation. 3. Education to be provided by the Regional Medical Director for the Center Physicians/Providers regarding the need for evaluation following a Resident readmission and documentation of their evaluation. Education to be provided by the Director of Nursing or designee to all Nurses (Full-Time, Part-Time, PRN and Agency) on all shifts and the weekends, regarding documentation of equipment usage. Staff shall not work until education is completed. Ongoing education to be completed during New Employee Orientation and Annual Education. 4. Unit Managers to audit all readmissions and admissions for follow-up and documentation of evaluation by the Provider weekly for four weeks and randomly thereafter to ensure compliance with Physician assessments and documentation to maintain the medical record. Unit Managers to audit three Residents receiving BiPaP treatment weekly for four weeks and randomly thereafter to ensure compliance with documentation. Results of this audit will	

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F 842	Continued From page 49 #298 read BIPAP (bilevel positive airway pressure), a device that helps with breathing every evening and night shift and as needed. Review of Resident #298's Treatment Administration Record (TAR) for April 2022 documented Resident #298 did not have her BIPAP applied on 4/20/22, night shift on 4/21/22 or night shift on 4/22/22. On 4/28/22 at 6:29 AM Nurse #9 stated he applied the BIPAP to Resident #298 on 4/20/22, 4/21/22, and 4/22/22. He stated he was new to the facility and may have forgotten to initial that he had done the treatment. An interview with the Director of Nursing on 4/28/22 at 2:10 PM revealed the TAR documentation was incorrect and she expected nurses to document treatments given.	F 842	be brought to Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 5/20/2022	