STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(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 onsite 5/2/2022 through 5/6/2022. The facility was found not in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ZHL011.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		5/31/22

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

Electronically Signed | 05/26/2022

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a facility and comprehensive Emergency Preparedness (EP) plan which had been developed, reviewed, and maintained specifically for the facility. The facility failed to maintain, review, and update the EP plan, update for current contacts, collaborate with local stakeholders, develop, update and review EP policies and procedures based on the developed EP plan, address subsistence needs for residents and staff, development of the communication plan, emergency official contact information, put into place EP training, testing, and establish a program, and document information in the EP regarding the emergency generator. Findings included: A review of the facility ' s supplied Emergency Preparedness plan material on 5/6/22 revealed: A. The supplied EP plan provided by the facility was a corporate EP plan and did not provide	E 001	The plan of correction outlined is only being completed per the North Carolina Nursing Home Licensure and Certification Section of the Division of Health Service Regulation guidelines and does not constitute any acceptance of, or admission to, the citations contained herein. E001 - Establishment of the Emergency Program 483.73 1. The Administrator started the process to corrected/updated the Emergency Preparedness plan in accordance with requirement CFR 483.73, Emergency Preparedness. The Emergency Preparedness plan will contain the required information to meet the health, safety and security needs of the resident population during any emergency or disaster situation. No specific residents were cited. 2. For all residents with the potential to be affected by the alleged deficit practice,	

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E 001	Continued From page 2 facility specific information, such as information about the facility staff, local surroundings, potential emergency specific situations related to the facility ' s location, information regarding local resources such as the fire department, information regarding the facility ' s emergency power, etc. ... in the event of an emergency. The plan referred to the Department of Health from Los Angeles, California in Appendix G emergency officials. B. The facility provided EP plan had not been reviewed or updated annually. Current facility staff were not listed in the plan. C. The reviewed EP plan did not address the procedures for EP collaboration with local, tribal, regional, state, and federal EP officials. D. The provided EP plan policies and procedures, emergency plan for risk assessment, and the communication plan were not reviewed and updated annually by the facility. E. The EP plan for communication was not facility specific, nor was it reviewed by the facility administration. F. There were no names nor contact information for facility specific staff, residents ' physician, and/or volunteers in the supplied EP plan. G. The names and contact information contained in the EP plan for emergency officials contact information was not facility specific (Nursing Home Licensure and Recertification and Ombudsman), nor was it reviewed and signed off by the facility administrator.	E 001	the following has been achieved: The Regional Director of Operations educated the Administrator and Maintenance Director on keeping the Emergency Preparedness Plan up to date and its location. Education completed by 05/26/2022. Administrator or Maintenance Director to educate all current facility staff including agency staff related to the location of the emergency preparedness notebook. 3. The Regional Director of Operations to monitor the Emergency Preparedness notebook for presence at designated locations 1x per week for 6 weeks, then 1x every other week for 4 weeks, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. Completion date: 05/31/22	

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E 001	Continued From page 3 H. The facility failed to provide information regarding training and testing for the facility specific EP plan. L. The facility failed to provide information regarding EP training program which would include training of the facility specific EP policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. M. The EP plan lacked facility specific information regarding the emergency generator location, inspection, testing, and fuel. On 5/5/22 an interview was conducted with the Administrator. The Administrator stated he was new to this facility Administrator position and that the emergency plan was not complete and needed to be updated. He started a general corporate EP plan. The Administrator stated he was not aware that the EP plan referred to the Los Angeles, California Department of Health and he was unable to provide information on what was in the EP plan including when it was reviewed and local information s	E 001		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted onsite from 5/2/2022 through 5/5/2022. Additional information was obtained on 5/6/2022 offsite. Event ID# ZHL011. The following intakes were investigated NC00186661, NC00187005, NC00187071, and NC00187590. 1 of the 10 complaint allegations was	F 000		

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F 000	Continued From page 4 substantiated resulting in deficiency F580.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		5/31/22

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F 550	Continued From page 5 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to replace the resident ' s lost bra. Without a bra the resident ' s breasts were revealed through her shirt. The resident wanted a bra to cover herself (Resident #19) for 1 of 5 residents reviewed for dignity. Findings included: Resident #19 was admitted to the facility on 4/16/19. Resident #19 ' s care plan dated 7/19/21 documented the resident was dependent on staff to meet her emotional, intellectual, physical, and social needs. Resident #19 ' s annual Minimum Data Set dated 4/7/22 documented the resident was oriented. She required minimal assistance or supervision with her activities of daily living. On 5/2/22 at 10:10 am an observation was done of Resident #19. She was in a 3-resident shared room, sitting on her bed, with her curtain drawn. The resident was dressed in pants and a shirt. She was clean. The resident had large breasts and they could be visualized through the thin, short-sleeve shirt without a bra. On 5/2/22 at 10:10 am an interview was conducted with Resident #19. She stated that the	F 550	F550 – Resident Rights/Exercise of Rights 483.10(a)(1)(2)(b)(1)(2) 1. The facility purchased Resident #19 three (3) bras, educated resident and assisted her with putting them on. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: The Director of Nursing completed an audit of all female residents and the facility corrected any resident needs as indicated. The Director of Nursing to educate all nursing staff on helping all residents dress appropriately. Education completed by 05/26/2022. All newly hired staff will be educated at time of hire. 3. The Director of Nursing or designee to monitor 5 female residents for proper dress weekly for 4 weeks, then 2x per month for 3 months, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. Completion date: 05/31/22	

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F 550	Continued From page 6	F 550		

facility had lost her bra months ago and could not find it. She stated she let the nurse know, but the bra could not be found and was not replaced. She stated she would like a bra to cover her chest, "a sports type bra with wide straps because I am wide around the back." The resident stated "I did not like not having a bra," I would wear my sweater to cover when out of my room.

On 05/02/22 at 11:45 am an interview was conducted with Medication Aide (MA) #1. She stated she was assigned to Resident #19 and knew her well. MA #1 stated that the resident does not wear a bra and had been braless for a while. MA #1 was observed to enter Resident #19 ' s room and ask her if she would like a bra and the resident stated "yes." MA #1 stated she would ask housekeeping to check the laundry for the resident ' s bra or an extra bra that was not being used. At 2:20 pm an interview was conducted with MA #1. She stated that housekeeping had no extra bras that would fit Resident #19.

On 5/3/22 at 9:00 am an observation was done of Resident #19. She was wearing a short-sleeve shirt without a bra. Her breasts could be visualized through the shirt. Resident #19 was interviewed and stated she was not provided a bra; staff could not find hers and there were no other bras to fit her.

On 5/3/22 at 9:20 am an interview was conducted with Social Worker #1. He stated that Resident #18 never wore a bra, she wears a coat even inside the facility. He stated he was not aware that the resident ' s bra was lost and that she requested a replacement. He stated that he

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F 550	Continued From page 7 "would look into it." On 5/4/22 at 2:15 pm an observation was done of Resident #18. The resident was sitting on her bed with the curtain drawn. She was wearing a short-sleeve shirt and her large breasts were visualized through her shirt. The resident was interviewed, and she stated no one had asked her about getting a bra. On 5/4/22 at 2:35 pm an interview was conducted with the Director of Nursing (DON). She stated Resident #18 usually wore a sweater and you could not tell if the resident was braless. The DON stated she was not aware the resident wanted a bra and would measure the resident and obtain a bra. On 5/5/22 at 5:28 pm an observation was done of Resident #18. She was sitting on her bed with her curtain open. She was dressed in a short-sleeve shirt and was wearing a bra. Interview was conducted with the resident, and she stated that the facility bought her a couple of bras and she was happy.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 553		5/31/22

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F 553	Continued From page 8 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on a family interview, staff interviews, and record review, the facility failed to invite the family of a cognitively impaired resident to participate in the planning of the residents' care. This occurred for 1 of 3 sampled residents reviewed (Resident #94). The findings included: Resident #94 was admitted to the facility 2/19/20 and re-admitted to the facility 3/29/22. Diagnoses included end-stage dementia, among others. Medical record review revealed there was no documentation of an interdisciplinary care	F 553	F553 □ Right to Participate in Planning Care 483.10(c)(2)(3) 1. Social Worker set up a care plan for Resident #94 as of 05/05/2022. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: All residents have the potential to be affected by not being invited to be part of their care plan meeting. Social Worker will review all current residents to ensure they have been invited to care plan meeting by 05/27/2022. All residents who have not been invited will be invited, including resident representative if applicable, as	

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F 553	Continued From page 9 conference for Resident #94 since August 2021. Medical record review revealed Resident #94's cognition was assessed as severely impaired on the quarterly Minimum Data Set (MDS) assessment dated 4/1/22. A family interview occurred on 05/02/22 at 12:55 PM and revealed the family had not been invited to participate in a care plan meeting regarding Resident #94's care in several months. The family stated she did not recall participating in a care plan meeting since the fall of 2021. During an interview with the social worker (SW) on 05/05/22 at 6:08 PM, the SW stated care plan meetings occurred in conjunction with the MDS assessment and that the resident or their responsible party were to be invited. The SW stated Resident #94's last care plan meeting was held on 8/10/21, the family was invited and attended. The SW further stated that since the facility did not have a MDS Nurse, the coordination of care plan meetings fell behind. The administrator stated in interview on 05/05/22 at 6:12 PM that care plan meetings were coordinated by the SW and should have been scheduled. He further stated that the care plan meetings for Resident #94 were either missed or not done correctly.	F 553	required to their next care plan meeting on their quarterly assessment review or as needed. The Administrator to educate the Social Work Director on appropriately scheduling all resident care plans. Education completed by 05/26/2022. Any newly hired Social Worker will be educated at time of hire. 3. The As of 5/30/2022, the Social Work Director will monitor assessment schedule weekly prior to due date to ensure all residents, including resident representative, if applicable, and/or family, are invited to care plan meeting for 3 months then monthly thereafter, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Social worker will report all findings to our monthly Quality Assurance and Performance Improvement Committee meeting for 3 months. All negative findings will be corrected immediately. Completion date: 05/31/22	
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	F 580		5/31/22

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

§483.10(g)(15)
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

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F 580	Continued From page 11 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner and legal guardian interviews the facility failed to notify a resident's legal guardian when Resident #357 was involuntarily committed to an acute care hospital for 1 of 1 resident reviewed for notification of changes (Resident #357). Findings included: Resident #357 was assessed to be legally incompetent on 01/10/2019. Resident #357 was admitted to the facility on 01/31/2019. Record review indicated Resident #357 was discharged from the Skilled Nursing Facility (SNF) on 03/01/22 to an acute care hospital. Nurse #3 documented on 03/01/2022 at 9:45 PM that Resident #357 was "transported to the Emergency Department." No additional information was provided. Nurse #3 was assigned to Resident #357 on 03/01/2022 and was not available to interview when she was contacted on 05/05/22 at 10:22 AM. A phone interview was completed with Resident #357's guardian on 05/05/22 at 3:11 PM. The	F 580	F580 – Notify of Changes (Injury/Decline/Room, etc.) 483.10(g)(14)(i)-(iv)(15) 1. Resident #357's guardian received notification of the transfer to hospital by the hospital. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: The Director of Nursing completed an audit of all residents transfers and no other residents were found to be affected. The Director of Nursing to educate all nursing staff on notifications to guardian or family member when a resident transfer takes place. Education completed by 05/26/2022. All newly hired staff will be educated at time of hire. 3. The Director of Nursing or designee to monitor resident transfer notifications 4x per week for 4 weeks, then 3x per week for 4 weeks, then 1x per week for 4 weeks, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has	

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	345115	A. BUILDING _____ B. WING _____	C 05/06/2022

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F 580	Continued From page 12	F 580		

guardian stated she received a call from the acute care hospital about midnight on 03/01/22. The hospital informed her that Resident #357 had been transported there after the Involuntary Commitment (IVC) process was done earlier that day. The guardian said she was not notified by the facility of the intent to complete the IVC process on 03/01/22 or her transfer until an email from Social Worker #1 was sent to her on 03/02/22.

On 3/02/22 at 11:25 AM an email was sent to the Guardian from Social Worker #1 at the Skilled Nursing Facility that noted that the Involuntary Commitment (IVC) was established with the magistrate office on 03/01/22 and the resident was currently at a local hospital.

A progress note written by the Director of Nursing (DON) on 03/02/2022 at 10:07 AM noted that on "03/01/22 at 5:30 PM, Resident #357 was discharged to the hospital after involuntary commitment papers were in place, and the resident left with the sheriff's department. Resident was to be admitted to a Mental Health hospital in the next few days."

An interview was conducted with Social Worker (SW) #2 on 05/03/22 at 3:47 PM regarding the discharge for Resident #357. SW #2 stated she did not notify the guardian that the IVC was complete or the discharge plans for that evening and they should have. She noted the nurse on duty should have notified the guardian also when the deputies came to take her to the hospital.

The DON was interviewed on 05/05/22 at 5:03 PM regarding Resident #357's discharge to the hospital. She acknowledged she was aware of

shown that it has improved adequately.
Completion date: 05/31/22

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F 580	Continued From page 13 the pending discharge on 03/01/22 after the Involuntary Commitment Paperwork had been completed. She stated the nurse should have notified the guardian of the discharge. An interview was completed with the Administrator on 05/05/22 5:16 PM who stated that he would expect that staff notify the responsible party or guardian if a resident was sent to the hospital.	F 580		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		5/31/22

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F 582	Continued From page 14 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to issue a notice to the resident or beneficiary prior to providing care that Medicare usually covers using the required form CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 3 of 3 residents reviewed for beneficiary protection notification review (Resident #'s 38, 53, and 158). 1. Resident #158 Medicare Part A started	F 582	F582 □ Medicaid/Medicare Coverage/Liability Notice 483.10(g)(17)(18)(i)-(v) 1. Resident #158, #53, #38 were issued form CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice). 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: The Interim Business Office Manager	

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F 582	Continued From page 15 1/12/22 and ended 4/23/22. Medicare benefits were exhausted, and no notice was provided. The resident applied for Medicaid and remained in the facility. 2. Resident #53 Medicare Part A started 7/1/21 and ended 12/2/21. Medicare benefits were exhausted, and no notice was provided. The resident applied for Medicaid and remained in the facility. 3. Resident #38 Medicare Part A started 8/3/21 and ended 12/23/21. Medicare benefits were exhausted, and no notice was provided. The resident applied for Medicaid and remained in the facility. On 05/05/22 at 9:29 am an interview was conducted with the Administrator. He stated that the beneficiary notices were not completed for the Medicare Part A notification benefit days exhausted timeframe reviewed, 7/1/21 through 4/23/22. He stated that he had no office manager and the notices were not being completed.	F 582	completed an audit of all residents eligible for change and corrected any that were found to be affected. The Administrator to educate the Interim Business Office Manager regarding notifications to residents and/or resident representatives who are eligible to receive form CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice). Education completed by 05/26/2022. Any newly hired Business Office Manager will be educated at time of hire. 3. The Administrator or designee to monitor resident transfer notifications 4x per week for 4 weeks, then 3x per week for 4 weeks, then 1x per week for 4 weeks, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Interim Business Office Manager will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. Completion date: 05/31/22	
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse,	F 607		5/31/22

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F 607	Continued From page 16 neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on review of the facility abuse policy and staff interviews the facility ' s abuse policy procedures to be put into place in the event sexual abuse is suspected for one of one facility abuse investigations reviewed. The Findings Included: Review of the facility policy titled Abuse, Neglect and Exploitation, with a revised date of 10/22/20, revealed the following: V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if	F 607	F607 – Develop/Implement Abuse/Neglect Policies 483.12(b)(1)-(3) 1. The Administrator completed an investigation for residents “suspected alleged sexual abuse” on 05/05/2022. Investigation by administrator shows suspected residents were safe and continue to be safe as of 05/05/2022. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: All resident have the potential to be affected by sexual abuse. The facility abuse policy was reviewed by the Regional Director of Operations for appropriateness to cover all areas of abuse to include sexual abuse. The Regional Director of Operations reviewed and updated the facility policy to include sexual abuse allegations and investigation as of 5/25/2022. The Regional Director of Operations educated the Administrator on the facility policy on abuse to include sexual abuse. Education completed by 05/26/2022. The Administrator and designee educated all staff on new abuse policy to include sexual abuse as of 5/27/2022. All newly hired staff will be educated at time of hire.	

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F 607	Continued From page 17 abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. A facility provided process which was titled, STEP A risk Management Process to manage Incidents, was reviewed. The process included: Step 1-Provide appropriate medical emergency care to the patient. Step 2-Notify physician and implement new orders. Step 3-Call the Administrator and Director of Nursing (DON)-DON to call Regional Director of Clinical Services (RDCS) as soon as possible (ASAP). Step 4-Begin the investigation immediately -Administrator and DON should go to the building. -Re-enactment; witness statements, timeline, chart review including the care plan. Step 5-Either Nursing Home Administrator (NHA)/DON/Regional Director of Operations (RDO)/RDCS call risk line. (provided phone number which ended in RISK) Step Triggers: included multiple examples of situations in which the process would be utilized including but not limited to falls with injury, elopement, suicidal ideation, resident to resident altercation or staff to resident abuse, and any allegation of sexual abuse. During an interview with the Administrator conducted on 5/5/22 at 2:21 PM he stated he felt the Abuse, Neglect and Exploitation policy did address sexual abuse allegations and how to investigate for not only sexual abuse, but other types of abuse which residents could experience.	F 607	3. The Administrator will monitor all abuse allegations daily in morning meeting for 4 weeks then weekly for 3 months to ensure all allegations are reported and investigated, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Administrator will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. Completion date: 05/31/22	

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F 607	Continued From page 18 An interview was conducted on 5/5/22 at 3:08 PM with the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS), and the Registered Nurse Consultant (RNC). The RDCS stated they had a risk process in place, in which anything unusual, such as suspected sexual activity, would be called into the "RISK" line. She explained the RISK line was a phone number which would be called by the DON or someone at the facility and a corporate person would answer the call and consult with the facility staff, consultant staff, and others involved as to how to manage the situation with best practice protocols. She further stated the abuse policy covers general information regarding abuse, the types of abuse, investigation of abuse, training, and reporting, but if something arises which may not be addressed by not only the abuse policy, but other policies, the resource of the RISK line would provide further information as to how to handle those situations. The DON stated she would be involved in calling the RISK line in the event there was a sexual situation at the facility and would receive direction as to how to proceed, which could include sending the resident out to a hospital for further assessment. The RNC stated the RISK line was part of the corporate support for facilities and she felt it, along with the STEP sheet process, which she provided, was an appropriate supplement to the abuse policy. The RCDS stated the abuse policy did not need to specifically identify what actions were necessary in the event of suspected abuse, such as sending to the hospital for a full assessment for suspected sexual abuse, because that would be a decision made during consultation through their RISK phone call.	F 607		
F 641 SS=D	Accuracy of Assessments	F 641		5/31/22

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F 641	Continued From page 19 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately assess section K0300, weight loss of 5% or more in the last month, of the quarterly Minimum Data Set (MDS) assessment for Resident #7. Additionally, the facility failed to accurately assess section J1300, current tobacco use, of the quarterly MDS assessment for Resident #79. This failure occurred for 1 of 3 sampled residents reviewed for nutrition and 1 of 1 sampled resident reviewed for smoking and had the potential to affect other residents. The findings included: 1. Resident #7 was admitted to the facility 11/19/21. Diagnoses included dementia, elevated basal metabolic index, hypothyroidism, hyperlipidemia, gastro-esophageal reflux disease and major depressive disorder, among others. Medical record review revealed the following weight history: - 3/4/2022, 151.0 pounds - 4/5/2022, 134.4 pounds (16.6-pound loss, 11% loss) A quarterly MDS assessment, section K0300, dated 4/15/22 assessed Resident #7 with no weight loss. This section of the MDS was completed by the dietary manager (DM).	F 641	F641 – Accuracy of Assessments 483.20(g) 1. The facility failed to accurately code Minimum Data Set (MDS) Comprehensive assessment in the area of Section J1300 (Current Tobacco Use) for Resident # 79 and Section K0300 (weight Loss) #7 MDS correction was initiated for resident # 79 on 5/23/2022 and resident # 7 on 5/26/22 and completed by MDS Nurse. 2. Residents who are currently using tobacco and tobacco products are at risk to be affected by the deficient practice. The MDS Nurse and Regional MDS Nurse completed an audit of the most recent MDS Comprehensive assessments completed and submitted on residents using tobacco and tobacco products. Audit completed to identify inaccurately coded assessments and issues identified will be corrected and MDS assessments will be resubmitted by 5/24/2022. Audit findings identified 3 incorrect Comprehensive assessments, with corrections submitted on 5/24/2022. Currents residents have the potential to be affected related to weight loss. The MDS nurse will complete an audit the current residents most recent quarterly assessments by 5/27/2022 to ensure that section K0300 is being coded accurately. Any identified corrections will be	

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F 641	Continued From page 20 An interview with the director of nursing (DON) on 05/05/22 at 11:42 AM revealed the nutrition section of the MDS was completed by the DM and that he was unavailable for interview. The DON further stated that the nutrition section of the quarterly MDS for Resident #7 was inaccurate and should have coded that Resident #7 sustained weight loss of 5% or more in the last month. 2. Resident #79 was admitted to the facility on 4/2/2021 with diagnosis that included unspecified dementia without behavior disturbances, non-Alzheimer's dementia, and slurred speech. Resident #79's electronic medical record revealed a smoking assessment dated 2/15/2022 was completed. Resident #79 was identified as being a current smoker who had no plans to stop smoking. Resident #79's care plan revealed the care plan was updated on 2/15/2022 to recognize Resident #79 as a smoker. Resident #79's Minimum Data Set (MDS) dated 3/23/2022 indicated Resident #79 was not a current tobacco user. During the Resident Council Meeting held on 5/3/2022 at 3:35 P.M., Resident #79 was in attendance and stated he used tobacco products. An interview was conducted on 5/5/2022 at 2:00 P.M. with MDS Nurse #3. The MDS Nurse #3 revealed she asked Resident #79 if he currently used tobacco products, Resident #79 replied no. The MDS Nurse #3 stated she did not follow up with a record review or staff to determine if	F 641	resubmitted. 3. The following measures have been put into place to ensure the deficient practice does not recur are, Facility MDS nurse(s) will be re-educated by the Regional MDS nurse on MDS assessment care areas pertaining to Section J1300 Current Tobacco Use and K0300(weight Loss). Education was completed by 5/24/2022. Newly hired MDS nurses to include agency MDS nurses will be educated upon hire. 4. The Director of Nursing or designee will complete an audit of MDS Assessment care area of J1300 and K0300 weekly for four (4) weeks, then bi-weekly for eight (8) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee monthly. Data will be brought by Administrator to review in Quality Assurance Performance Improvement Committee meetings and changes will be made to the plan as necessary to maintain compliance with comprehensive assessments and timing. Completion Date: 5/31/2022	

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F 641	Continued From page 21 Resident #79 used tobacco products. An interview conducted on 5/5/2022 at 3:36 P.M. with the Director of Nursing (DON). The DON revealed Resident #79's was assessed to be a supervised smoker on 2/15/2022, when Resident #79's wife brought him a tobacco pipe. The DON further stated Resident #79 has smoked since his wife delivered the tobacco pipe. During the interview the DON stated the MDS should reflect Resident #79 was a current tobacco user and staff should accurately document resident information.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645		5/31/22

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F 645	Continued From page 22	F 645		

authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an

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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 645	Continued From page 23 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit information for Preadmission Screening and Resident Review (PASSR) for a level 2 re-evaluation for 2 of 2 residents reviewed for PASSR (Residents #12, #44). Findings include: 1. The facility admitted Resident #12 to the facility on 09/18/2017 with diagnoses of, in part, diffuse traumatic brain injury and stroke, anxiety and depression. The PASRR letter for Resident #12 dated 09/14/2017 indicated a PASRR Level I. The letter noted, "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." Review of the medical diagnosis listed in the medical record for Resident #12 indicated the following diagnosis and dates: Schizophrenia 06/14/21 and an adjustment disorder with anxiety and depression 04/08/22. An annual Minimum Data Set (MDS) assessment dated 7/14/21 for Resident # 12 was marked "No" for serious mental illness and "No" for evaluation for Level II PASRR. Diagnoses included in the	F 645	F645 □ PASARR Screening for MD & ID 483.20(k)(1)-(3) 1. On 05/05/2022, the Social Work Director completed and submitted a level II PASRR review to North Carolina Medicaid Uniform Screening Tool (NC MUST) for residents #12, #44 related to a new mental health diagnosis of schizoaffective disorder on 5/4/21. Upon determination of review, the MDS coordinator will complete a modification to the comprehensive MDS assessment if indicated. 2. On 05/07/2022, the Social Worker and MDS coordination completed an audit of residents with newly evident or possible serious mental health disorders for accurate PASRR level assessment. A review of active diagnosis reports for resident current medical record in PCC and of Psych consult notes were compared to residents most recent comprehensive MDS assessment for accuracy of PASRR level. The Social Work Director will complete and submit level II PASRR reviews to NCMUST if indicated. 3. On 05/26/2022, the Regional Clinical Reimbursement Consultant nurse provided education to the Social Worker and MDS coordinator on the process of referring all residents with newly evident or possible serious mental disorders for	

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F 645	Continued From page 24 MDS assessment were anxiety disorder, depression, psychotic disease and schizophrenia. Medications included during the 7 day look-back period included antipsychotics, anti-anxiety medication and antidepressant medication for 7 of the 7 days. A quarterly MDS dated 01/04/22 revealed Resident #12 received antipsychotic medication 7 out of 7 days of the look back period. A review of the care plan for Resident #12 revealed focus areas of risk of: -potential to be verbally aggressive related to Schizophrenia. This was initiated on 11/04/2020 and revised on 03/07/2021. -medication side effects as used psychotropic medications related to Schizophrenia. This was initiated 05/17/2019 with a revision date of 07/14/2021. -medication side effects as received anti-anxiety medications related to an anxiety disorder. This was initiated on 09/28/2017 and revised on 03/07/2021. -medication side effects as received antidepressant medication related to Depression. This was initiated on 09/28/2017 with a revision date of 09/09/2021. -medication side effects as received antipsychotic medications related to his disease process with dx of depression and delusional disorder. This was initiated 03/25/2018 with a revision on 07/14/2021. On 05/05/22 at 4:29 PM an interview was conducted with Social Worker (SW) #1 regarding	F 645	level II resident review upon a significant change in status assessment. The SW and/or MDS coordinator will identify residents needing PASRR review by monitoring Psych consult notes and new orders for newly evident or possible serious mental health disorders. The SW will submit level II PASRR reviews as indicated. Newly hired SWs and MDS coordinators will receive education upon hire. 4. The Director of Nursing or designee will complete quality assurance monitoring of Psych consult notes and physician orders to identify residents with newly evident or possible serious mental disorders for PASRR level II screening. Monitoring will be completed weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Quality Assurance and Performance Improvement Committee meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with level II PASRRs. Completion date: 05/31/22	

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Resident #12. He said he had been the SW at the facility for 2 years. The SW stated the resident should have been considered for a PASSR level 2 as he had multiple diagnoses. He stated he was responsible for submitting it to North Carolina Medicaid Uniform Screening Tool (MUST) as a PASSR review and had missed it. The SW said no review was done and he did not apply for the assessment for Resident #12.

The Director of Nursing was interviewed on 05/05/22 at 5:00 PM regarding PASSR II evaluation. She stated the Social Workers were responsible for submitting the evaluations and she would follow up with them.

An interview was done with the Administrator on 05/05/22 at 5:16 PM regarding the PASSR II evaluation. He said the PASRR should be reviewed to make sure they were appropriate and reevaluated if there was a change.

2. The facility admitted Resident #44 to the facility on 09/21/17 with diagnoses of, in part, bipolar disorder, schizoaffective disorder, depression and anxiety disorder.

The PASRR letter for Resident #44 dated 12/31/14 indicated a PASRR Level I. The letter noted, "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions."

Review of the medical diagnosis for Resident #44 indicated the following diagnoses and dates: Schizo-affective disorder 09/25/20 and Major

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depressive disorder 02/25/21.

An annual Minimum Data Set (MDS) assessment dated 08/11/21 for Resident #44 revealed it was marked "No" for serious mental illness and "No" for evaluation for Level II PASRR. Diagnoses included in the MDS assessment were anxiety, depression, manic depression and schizophrenia. Medications included during the 7 day look-back period included antipsychotics and antidepressant medication for 7 of the 7 days, and anti-anxiety medication for 2 of the 7 days.

A quarterly MDS dated 02/09/22 was reviewed for Resident #44 and noted the PASRR Level II and serious mental illness assessment was not marked. The assessment indicated Resident #44 received antipsychotic and antidepressant medications for 7 out of 7 days of the look back period.

A review of the care plan for Resident #44 revealed a focus area of risk of:
-medication side effects as received anti-anxiety medications related to an anxiety disorder. This was
initiated on 10/05/17
-the resident has potential to be physically aggressive related to a bipolar disorder and an anxiety
disorder. This was initiated on 07/26/19 and revised on 10/19/20.

A Psychiatric Progress note dated 04/20/22 indicated Resident #44 had a follow-up visit for recent behaviors and care coordination with SW and nursing. It noted he had a Major Depressive Disorder, anxiety disorder and an intermittent "explosive" disorder.

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F 645	Continued From page 27 On 05/05/22 at 4:29 PM an interview was conducted with Social Worker #1 regarding Resident #44. The SW noted he had been working at the facility for 2 years. The SW stated the resident should have been considered for a PASSR level 2 as he had multiple diagnoses. He stated he was responsible for submitting it to North Carolina Medicaid Uniform Screening Tool (MUST) as a PASSR review. The SW said no review was done and he did not apply for the assessment for Resident #44, that he had missed it. The Director of Nursing was interviewed on 05/05/22 at 5:00 PM regarding PASSR II evaluation. She stated the social worker was responsible for submitting those and she would follow up with them. An interview was done with the Administrator on 05/05/22 at 5:16 PM regarding the PASSR II evaluation. He said the PASRR should be reviewed to make sure they were appropriate and reevaluated if there was a change.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		5/31/22

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F 655	Continued From page 28 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be 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 provide 1 of 4 residents, Resident #307, with a Baseline Care Plan which addressed behaviors such as attempting to touch staff members inappropriately and making sexually	F 655	F655 – Baseline Care Plan 483.21(a)(1)-(3) 1. Resident #307 Care Plan was updated on 05/07/2022 by the Director of Nursing to address resident behaviors to	

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F 655	Continued From page 29 inappropriate comments. The findings included: Resident #307 was admitted to the facility on 4/26/22 and his admission diagnoses included stroke, diabetes, altered mental status, psychosis, depression, and dementia. Review of Resident #307 ' s Baseline Care Plan (BCP), which was dated 4/26/22 revealed no information addressing behaviors for the resident. The resident was documented as having had cognitive impairment with dementia. The BCP was initiated by Nurse #7. A review completed of Resident #307 ' s progress notes revealed a note written by Nurse #6 which was dated 4/26/22 and timed 9:36 PM revealed the resident was documented as being ambulatory, going into and out of other people ' s rooms, and having sexual inappropriate behavior. Another progress note for Resident #307, which was dated 4/27/22 and timed 6:09 AM, written by Nurse #7, documented the resident had been up all night, was pacing the floor, rummaging in other residents ' rooms, was very hard to redirect, exhibited sexual behaviors towards staff, and it was attempted to monitor closely through the night. A progress note dated 4/28/22, and timed 11:53 PM, for Resident #307, written by the Nurse Practitioner (NP), documented the resident was reported by staff to have been wandering around the facility and making inappropriate sexual advances. She further documented the resident had been transferred to the locked unit due to his	F 655	include attempting to touch staff members inappropriately and making sexually inappropriate comments. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: All current residents have the potential to be affected. The Director of Nursing will complete audits of the new admission in the past 30 days by 05/26/2022 to ensure baseline care plans are being completed to include resident behaviors. Licensed nurses to include agency licensed nurses will be educated by 05/26/2022 by the Director of Nursing or designee to ensure baseline care plans are including resident behaviors. New hire nurses and agency licensed nurses will not be able to work until the education has been completed. 3. The Director of nursing will complete audits of the new admissions weekly for 4 weeks and monthly for 2 months to ensure base line care plans include resident behaviors, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Completion date: 05/31/22	

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behaviors.

An interview was conducted on 5/3/21 at 2:31 PM with Nurse #6. During the interview the nurse stated Resident #307 was going into and out of several different resident rooms the night he was admitted on 4/26/22. She stated he had touched her and one other female staff member on the buttocks. She explained the resident was telling her and the other female staff that he liked them and because of these behaviors she had alerted the staff to keep an eye on him and to monitor him. She said the resident was redirected quite easily when he was wandering. She further explained she had admitted the resident during the 2:00 to 10:00 PM, before dinner, and she explained to the oncoming nurse, 10:00 PM to 6:00 AM, Nurse #7, about the resident ' s behaviors. The nurse also stated she had alerted the DON about the resident and his behaviors.

During an interview conducted on 5/3/22 at 2:46 PM with Nurse # 4 she stated on 4/27/22, when she arrived for the 6:00 AM to 2:00 PM shift, Resident #307 was still up, he was wandering up and down the hall, but was still easily redirectable. She said he had stated he was looking for his room. She said she did remember there had been a young Nursing Assistant (NA) who had told her Resident #307 had touched her on her buttocks.

An interview was conducted with Social Worker (SW) #1 on 5/5/22 at 12:32 PM. The SW stated Resident #307 was moved to the locked unit on 4/27/22 and he did not know anything about his sexual behaviors, and no one had discussed the resident ' s behaviors with him. The SW stated he had participated in the clinical meeting where

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F 655	Continued From page 31 resident ' s progress notes were reviewed, but he was not aware of reviewing the resident ' s progress notes regarding the inappropriate sexual behaviors, nor any other behaviors of the resident. The SW stated he was not aware of the documentation from 4/26/22, 4/27/22, and 4/28/22, but if he had been aware, he would have been the person to update the resident ' s baseline care plan. During an interview with the Director of Nursing (DON) conducted on 5/5/22 at 3:08 PM she stated Resident #307 ' s inappropriate sexual behaviors were discussed in the daily clinical meeting. She further stated the inappropriate sexual behaviors and comments were not in the BCP and should have entered into his BCP.	F 655		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		5/31/22

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F 688	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply bilateral hand and elbow splints as ordered to a resident with contractures for 1 of 1 resident reviewed for range of motion (Resident #106). Findings include: Resident #106 was admitted on 01/09/19 to the facility with diagnoses that included functional quadriplegia and muscle weakness. The medical record indicated additional diagnoses of right and left hand contractures on 09/08/21. The Quarterly Minimum Data Set (MDS) assessment dated 04/05/22 indicated Resident #106 was moderate cognitively impaired. It indicated he had impairment of both of his upper extremities. He required extensive assistance of 1 person with eating, dressing, bathing, and 2 people to assist with bed mobility. He had no rejection of care or behaviors. Review of the physician orders 06/15/20 indicated an order for Restorative Nursing program to don and doff bilateral elbow extension splints and bilateral upper extremity splints for contracture management 5 times a week ongoing. The care plan for Resident #106 listed care areas that Resident #106 required staff assistance for all care related to his limited physical mobility due to disease processes. This was initiated on 07/15/2019 and revised on 05/02/2021 with interventions that included the Restorative	F 688	F688 □ Increase/Prevent Decrease in ROM/Mobility 483.25(c)(1)-(3) 1. Resident #106 splints was reviewed by therapy on 05/07/2022 to ensure the resident□s bilateral hand and elbow splints are being applied as ordered to maintain the resident contractures. 2. All current residents have the potential to be affected. An audit will be completed by the Director of Nursing or designee by 05/26/2022 to ensure splints are being applied as required. All licensed nurses, restorative aides, CNAs to include agency licensed nurses, restorative aides, CNAs will be educated by the Director of Nursing or designee to ensure splints are being applied as ordered. New hires to include agency licensed nurses, restorative aides, CNAs, will not be allowed to work until the education is completed. 3. The Director of nursing will complete audits of 4 residents that require splints weekly for 4 weeks and then monthly for 2 months to ensure splints are being applied as required, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Completion date: 05/31/22	

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Nursing program to follow physician orders to maintain functional abilities which was initiated on 12/02/20 and revised on 03/11/21. Interventions also included for restorative staff to do splinting of upper extremities with elbow extension splints 4-6 hours a day, 3-5x week x 12 weeks initiated: 03/11/2021 with no discontinued date.

An observation was made on 05/03/22 at 10:19 AM of Resident #106 lying in bed with bilateral hand contractures and his elbows were bent upward and his left hand was clenched and the middle finger on his left hand was straight out. Other fingers were clenched in the contracture and the fingers or nails were not visible.

An interview was conducted with Resident #106 about his hands on 05/03/22 at 10:20 AM. He said he was not able to open his hands. He stated he had splints but needed someone to put them on. He noted when his splints were on his hands, they would be open all the time. The resident further indicated his splints had not on in quite a while.

Resident #106 was observed on 05/04/22 at 9:00 AM resting in bed, with no splints on his arms.

A follow up interview was done on 05/04/22 at 9:01AM with Resident #106. He stated he had "no splints on now for many days." He denied pain at present but stated he has pain when he tried to open his hands.

Nurse Aide (NA) #3 was interviewed on 05/04/22 at 9:35 AM regarding Resident #106's splints. She stated she had not cared for him much and she was not aware of any devices or splints for his elbows or hands. She stated they did not put

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splints on, she thought someone in restorative care put the splints on and she had seen them on him once.

An interview was done with Medication Aide #2 on 05/04/22 at 12:39 PM, that was assigned to Resident #106 frequently. She stated she did not recall splints being on the resident when she gave him medications. She noted they had someone come and put splints on, nursing did not do it. She thought it might be therapy.

Nurse #5 was interviewed on 05/05/22 at 10:59 AM regarding Resident #106's splints. She was asked about his splints and stated she was nurse on the unit. She thought "splints were on him at least 2-3 times a week but she was not sure." She had never put them on him and was never told he had refused his splints. She noted on weekends restorative staff were not there and every other weekend when she worked the splints were not put on.

An observation was done of Resident #106 on 05/05/22 at 11:03 AM. He did not have splints on his upper arms.

Resident #106 was interviewed on 05/05/22 at 11:05 AM about his splints. The resident said he asked the staff for his splints this morning, but the staff never came back in the room. He said, "it was hit or miss getting them on."

An interview was done with NA #1 on 05/05/22 at 11:07 AM. The NA said she had seen splints on Resident
#106's arms. She noted he would ask her to take them off at times, but she said, "there was a person that puts them on." She was not aware of

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the frequency or length of time they should be on and was not sure if they were listed on his care plan or the Kardex. She reviewed the Kardex and saw an intervention for heel protectors but not splints.

An interview was done with Restorative Aide #2 on 05/04/22 at 1:08 pm and she was asked about Resident #103's splints. She stated only restorative staff applied splints during the week, and on occasion you might find a Nurse Aide (NA) who would offer to apply the splint for a resident. She said he had hand and elbow splints and if he refused, she would tell the nurse and the therapy director, and she documented the refusal. She said they would rotate his hand and elbow splints and the last time she put splints on him was about 4 weeks ago. She was asked to provide the last three weeks of documentation as the forms were not in the medical record.

On 05/04/22 at 1:20 PM Restorative Aide #2 provided a worksheet on splints for the facility from 03/28/22 to 4/8/22. These were the last records they had to date she noted. Resident #106 was only listed on the sheets from 3/28-4/1/22 and had refused splints on 3/29/22 and was checked off 4 days that week as applied. She noted on 03/31/22 she applied an elbow splint, and on 04/01/22 she applied a splint to the hand. The resident was not listed on the sheet for 4/4/22 or 4/5/22, documented on 4/6 for splint on and as refused on 4/7/22 and 4/8/22. Additionally, on 04/04/22 and 04/05/22, it was noted on the worksheet that exercises and splints were not done as restorative staff were "working and finishing up monthly weights for April!" Restorative Aide #2 said the splints were not done on the weekends as the restorative staff

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were not there and the staff on the units usually did not apply the splints.

A follow-up interview was done on 05/04/22 at 5:12 PM with Restorative Aide #2. She noted she had been training in the business office to help as an assistant there and not doing restorative care. She said the NA's on staff were expected to do it on the weekend and there were no logs for 3 weeks as worked on weights and no splints were done.

Restorative Aide #1 was interviewed via phone on 05/05/22 at 2:05 PM regarding splints. She noted residents would usually wear splints for 4-6 hours at a time. On occasion some residents requested it on a different schedule for splints being on and off if they can't tolerate it. She noted Resident #106 was to wear his splints but the last few weeks she was doing the monthly weights or had to go with residents to physician appointments, so she did not do the splints. She noted Resident #106 had no splints put on in a few weeks. She said Resident #106 would wear his splints with an occasional refusal. She was asked about the documentation of splints that was requested and informed March and April did not have consistent documentation and no splints were placed in the last few weeks. She stated the restorative aides had been asked to do other duties and could not always apply splints. She stated if a resident refused a splint she would try back later in the day.

The Director of Nursing (DON) was interviewed on 05/05/22 at 4:41 PM regarding the application of splints. She stated the splints should be on if ordered and restorative staff should let the unit staff know if they can't place them that day. She

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F 688	Continued From page 37 was asked how the NA's would know about the splints and the DON said the splint information should be added to the Kardex. The DON noted also on weekends the staff on the unit should put them on since Restorative Care was Monday-Friday. An interview was conducted with the Administrator on 05/05/22 at 5:16 PM in reference to splints for contracture management. He said staff should attempt to put splints on and document if refused. He stated they should follow the orders as written and the splints should be on the care plan/Kardex for staff to be aware of the orders.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		5/31/22

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F 692	Continued From page 38 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow a recommendation from the Registered Dietitian (RD) to reweigh a resident after an assessment of significant weight loss (Resident #7). This failure occurred for 1 of 3 sampled residents reviewed for nutrition and had the potential to affect other residents. The findings included: Resident #7 was admitted to the facility 11/19/21. Diagnoses included congestive heart failure (CHF) causing altered cardiac output, dementia, elevated basal metabolic index (BMI), hypothyroidism, hyperlipidemia, gastro-esophageal reflux disease and major depressive disorder, among others. A review of February 2022 physician order summary for Resident #7 revealed an order for Lasix (diuretic) 20 mg, twice daily for 5 days and then 20 mg daily, due to lower extremity edema (swelling) and CHF (altered cardiac output). A care plan, revised March 2022, identified Resident #7 was at nutritional risk due to a history of elevated BMI, altered cardiac output, and abnormal labs. The interventions included to monitor weights. A review of April 2022 physician order summary for Resident #7 revealed an order to discontinue Lasix 20 mg daily and start Lasix 20 mg, 3 days per week, Monday, Wednesday, and Friday, due to CHF.	F 692	F692 – Nutrition/Hydration Status Maintenance 483.25(g)(1)-(3) 1. Resident #7 was reweighted on 05/05/2022 by nursing unit manager. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: All current residents have the potential to be affected. An audit will be completed on 05/10/2022 the Director of Nursing of the current resident weights to ensure reweights are being completed as required. The Registered Dietitian recommendations will be reviewed by the Director of Nursing by 05/10/2022 for the last 30 days to ensure recommendations, to include reweights, are being completed as required. The licensed nurses to include the agency licensed nurses will be educated by 05/26/2022 by the Director of Nursing or designee to ensure residents are being reweighted as required and Registered Dietitian recommendations are being completed. New hire licensed nurses to include the agency nurse will not be allowed to work until the education is completed. 3. The Director of Nursing will complete audits of the monthly weights and the monthly Registered Dietitian recommendations monthly for 3 months to ensure recommendations are being completed and reweights are being done as required, or until substantial compliance is met per the Quality Assurance and Performance	

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F 692	Continued From page 39 Medical record review revealed the following weight history with no further weights recorded for April 2022: - 3/4/2022, 151.0 pounds - 4/5/2022, 134.4 pounds (16.6-pound loss, 11% loss) A quarterly Minimum Data Set assessment, dated 4/15/22, assessed Resident #7 with severely impaired cognition, able to feed herself with staff supervision after assistance with tray set up, and no weight loss. A 4/19/22 Weight Warning progress note written by the RD, recorded that Resident #7 sustained 11% weight loss in 30 days with diuretic therapy contributing to the weight loss. The RD recommended to reweigh Resident #7 for the 17-pound weight loss in one month, staff to offer an evening snack to stop further losses and continue nutritional monitoring with weights and food intakes. An interview with restorative aide (RA) #1 occurred on 05/04/22 at 12:06 PM and revealed she was responsible for completing monthly weights along with RA #2. The RA #1 further stated that she received a list from the director of nursing (DON) for any residents who required more frequent weight monitoring like a reweigh, daily, weekly, or twice weekly weights. RA #1 stated she was not aware that Resident #7 required a reweigh and that the Resident only had monthly weights done. An interview with RA #2 occurred on 05/04/22 at 1:08 PM. RA #2 stated Resident #7 was last weighed on Friday, 4/29/22, for her monthly weight monitoring. RA #2 stated she was not	F 692	Improvement Committee. 4. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Completion date: 05/31/22	

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aware that Resident #7 needed a reweigh after the 4/5/22 weight, which would be communicated to her by either the DON or a nurse.

A telephone interview with the RD occurred on 05/04/22 at 1:19 PM. The RD stated she had access to weight data once it was input into the facility electronic medical record system and from that data, she generated a weekly Weights and Vitals Exception report which would capture any resident with significant weight loss. She stated this report was faxed to the DON. The RD stated that when she considered recommendations, she reviewed the resident's food intake for the prior 14 days and physician orders for any medications that could impact weight. The RD stated that when Resident #7 triggered for significant weight loss, she noted that the Resident received a diuretic that would affect her weight status, so she recommended a reweigh and evening snacks to prevent any further weight loss. The RD stated that a 17-pound loss in one month was significant even for a resident on diuretic therapy and she recommended the reweigh to make sure there were no other contributing factors for the weight loss. The RD stated she had not received a response to this recommendation from the DON.

The DON was interviewed on 05/05/22 at 11:42 AM and stated that once she received the RD recommendations, she discussed them with the nurse practitioner (NP), wrote the order and faxed the approved recommendations back to the RD. The DON requested time to review the Resident's medical record. During a follow up interview with the DON on 05/05/22 at 1:56 PM, she stated that she did receive the April 2022 RD recommendations, but that she had no documentation on how the facility responded. The

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F 692	Continued From page 41 DON stated that she just spoke to the NP, but they could not recall why the facility did not complete the recommendation. The DON further stated that typically reweighs were completed the day the recommendations were received or the next day and that the facility should have responded to the RD regarding this recommendation. A telephone interview with NP #1 occurred on 5/5/22 at 2:16 PM, the NP stated she was the NP at the facility until Friday 4/15/22. The NP stated typically she and the DON would review the RD recommendations and discuss whether to make it an order or not, but she could not recall the discussion regarding Resident #7. Attempts to reach NP #2 were unsuccessful.	F 692		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, physician, nurse practitioner, and resident interviews, the facility assessed the resident ' s numeric rating scale for pain, but failed to assess the burning, stabbing, and numbness pain for a diabetic resident during auto-amputation (to fall off when the tissue was dead) of toes for 1 of 2 residents reviewed for pain.	F 697	F697 – Pain Management 483.25(k) 1. Resident #48 pain was reassessed by the Medical Director on 05/04/2022 to address the burning, stabbing, and numbness pain for the diabetic resident during auto-amputation. The resident received new orders on 05/04/2022. 2. For all residents with the potential to be affected by the alleged deficit practice,	5/31/22

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F 697	Continued From page 42 Findings included: Resident #48 was admitted to the facility on 2/4/22 with the diagnoses of frost bite to the feet and diabetes. Resident #48 ' s physician order dated 2/5/22 documented Hydrocodone-Acetaminophen Tablet 5-325 mg (milligram) give 1 tablet by mouth every 6 hours as needed for pain and was discontinued on 3/8/2022. Resident #48 ' s nurse practitioner note dated 2/8/22 documented Resident #48 was living in his van and was found by a friend and taken to the hospital. The resident ' s feet had frost bite. His toes progressively became necrotic 4 toes on the right foot and 3 toes on the left foot. An ultrasound showed mild vascular disease in the right lower extremity and arterial showed no significant flow and the vascular surgery physician recommended to allow his toes to auto amputate (fall off on their own as the tissue dies). The resident had some pain at times in his feet reported as "8" on a pain scale 1 to 10 with 10 being the worse. Hydrocodone/APAP decreased the pain level to a 3-4 after administration. Resident #48 ' s Minimum Data Set dated 2/9/22 documented the resident was oriented and was assessed for pain which revealed there was scheduled pain medication and no pain during the assessment. Resident #48 ' s care plan dated 2/19/22 documented he was a diabetic and he had frost bite to the feet with an infection and the intervention was antibiotic. The resident had pain to his feet and the intervention was pain	F 697	the following has been achieved: All current residents have the potential to be affected. The Director of Nursing or designee will complete an audit by 05/26/2022 to ensure that current resident pain is being addressed to include diabetic pain. The Licensed Nurses to include agency licensed nurses will be educated by 05/26/2022 by the Director of Nursing or designee to ensure that resident pain is being addresses to include diabetic pain. New hires to include agency licensed nursing will not be allowed to work until the education is completed. 3. The Director of Nursing will complete audits of 5 current residents weekly for 4 weeks and monthly for 2 months to ensure resident pain to include diabetic pain is being addressed in the facility, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Completion date: 05/31/22	

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management.

Resident #48 ' s physician order dated 3/8/22 documented Hydrocodone-Acetaminophen Tablet 5-325 mg give 1 tablet by mouth every 8 hours as needed for pain and was discontinued on 3/30/22.

Resident #48 ' s nurse practitioner note dated 3/10/22 documented the resident was seen today for feet wounds. Hydrocodone-Acetaminophen Tablet 5-325 mg give 1 tablet by mouth every 8 hours as needed for pain was ordered.
Evaluation of frostbite of feet were as follows:
#1 Blister plantar right 4.5 by 3 by 0 centimeter (cm)
#2 frostbite 1st toe right 5 by 5 by 0 cm
#3 frostbite 2nd toe right 1 by 1 by 0.1 cm
#4 frostbite 3rd toe right 2 by 1.5 by 0.1 cm
#5 Frostbite 4th toe right 2 by 1.5 by 0.1 cm
#6 frostbite 5th toe right 2 by 1.5 by 0.1 cm
#7 Frostbite Plantar left 1.5 by 1 by 0 cm
#8 Frostbite 1st toe left
#9 Frostbite 2nd toe left 1.5 by 1 by 0 cm
#10 Frostbite 4th toe left 1 by 2 by 0 cm
#11 Frostbite 5th toe left2 by 2 by 0 cm

Resident #48 ' s nurse practitioner note dated 3/29/22 documented the resident was seen today at request of the nurse due to increased pain to bilateral feet. The resident has frostbite on bilateral toes and seen today to evaluate pain. The resident was on Hydrocodone/Acetaminophen 5/325 mg one tablet every 8 hours as needed. The resident reported he usually had one pain pill in the morning then at about 4pm and it was too early to have one before bedtime on every 8-hour schedule. The resident had pain to his feet

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wounds. Staff to increase hydrocodone/Apap 5/325 one every 6 hours as needed and continue to monitor.

Resident #48 ' s nurse practitioner note dated 4/15/22 documented the resident was seen today at the request of the nurse to evaluate some drainage on frostbite toes. The frostbite of right foot and left foot and superficial frostbite of right and left toes with moderate amount of drainage serous and odor. The resident was to follow up with the vascular surgeon and start Doxycycline 100 mg by mouth twice a day for 7days (antibiotic). The resident ' s pain due to frostbite on multiple toes and bilateral feet had improved with increased hydrocodone/Acetaminophen 5/325 milligrams one every 6 hours as needed continue to monitor.

Resident #48 ' s physician order dated 4/19/22 Hydrocodone/Acetaminophen Tablet 5-325 mg Give 1 tablet by mouth every 6 hours as needed for pain level 1-5. Must separate from all hydrocodone administrations by 6 hours and give 2 tablets by mouth every 6 hours as needed for pain level 6-10 for 30 Days. Must separate from all hydrocodone administrations by 6 hours (pain level on a scale of 1-10 with 10 being the worst).

Resident #48 had a physician order dated 4/28/22 for wound care: right 3rd toe, right 4th toe, right 5th toe, and left 5th toe cleanse with Dakin's solution, pat dry, apply silver alginate in between toes, apply skin prep to eschar and change Monday, Wednesday, and Friday.

Resident #48 had a physician order dated

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4/28/2022 for wound care: right great toe, right lateral foot, left lateral foot, left heel, left 2nd toe, and left 4th toe cleanse with normal saline, pat dry, and apply skin prep daily.

Resident #48 ' s nurse practitioner note dated 4/23/22 documented the resident was seen today for wound and pain management follow-up. The resident reported continued pain in bilateral feet. He denies any change in pain since increasing his pain medication. Due to worsening discoloration of toes on bilateral feet and necrosis the vascular surgeon recommended to allow toes to auto amputate and continue wound care. The resident had black, necrotic toes to left 2nd, 3rd, 4th and right 1st, 3rd, 4th, and 5th toes. The resident had right 4th toe loose and near completion of auto amputation and a large necrotic area to left heel. The nurse practitioner provided a new medication order for pain due to gangrene, acute and worsening pain. Staff was to administer hydrocodone/APAP 5-325 mg 1 tablet by mouth every 6 hours as needed pain rated at 1-5, or 2 tablets by mouth every 6 hours as needed for pain rated as 6-10.

A review of Resident #48 ' s nurses ' notes documented that the resident ' s pain assessment was completed by a pain level of 1 to 10 with 10 being the worst. There were no notes documented about the type of pain the resident had experienced. The pain level was documented in the treatment and medication administration records.

Treatment administration recorded pain level observation by shift were documented as follows:
4/1/22 day shift 0 (pain) evening and night 4
4/2/22 day shift not documented, evening 7, night

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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 697	Continued From page 46	F 697		

0
4/3/22 day shift 0, evening and night 5
4/4/22 day and evenings 0 and nights 5
4/5/22 day shift 7, evening and night 0
4/6/22 day shift 7, evening 0 and night 2
4/7/22 day shift 4, evening 3 and night 0
4/8/22 day shift 2, evening 2, and night 2
4/9/22 day shift 8, evening 7, and night 1
4/10/22 day, evening and night 5
4/11/22 day 4, evening and night 0
4/12/22 day, evening and night 0
4/13/22 day 3, evening and night 0
4/14/22 day 4, evening 3, and night 0
4/15/22 day, evening and night 0
4/16/22 day 4, evening 3, and night 0
4/17/22 day 0, evening and night 5
4/18/22 day 7, evening 7 and night 0
4/19/22 day 8, evening and night 0
4/20/22 day 7, evening and night 0
4/21/22 - 4/23/22 all shifts 0
4/24/22 day 0, evening 3, night 0
4/25/22 day 6, evening 0, night 3
4/26/22 day 3, evening 0, night 1
4/27/22 day and evening 0, night 6
4/28/22 day, evening and night 3
4/29/22 day 3, evening and night 0
4/30/22 day 0, evening 7, and night 0
5/1/22 day shift 0, evening and nights 6
5/2/22 day, evening and night 0
5/3/22 day 3, evening and night 0
5/4/22 day 5 end of review

Medication and associated pain level before administration by shift were as follows:
4/1/22 8:10 am pain 7 and 2:43 pm pain 4
4/2/22 2:15 pain 7 and 8:20 pm pain 7
4/3/22 8:46 am pain 4 no further documentation
4/4/22 3:07 pm pain 8 and 7:35 pm pain 4
4/5/22 7:50 am pain 8 and 2:35 pm pain 8

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	345115	A. BUILDING _____ B. WING _____	C 05/06/2022

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4/6/22 8:12 am pain 7 and 2:38 pm pain 6
4/7/22 8:11 am pain 7 and 12:15 pm pain 0
4/8/22 3:43 pain 8
4/9/22 8:16 am pain 7 and 3:13 pm pain 7
4/10/22 7:45 am pain 7
4/11/22 12:30 pm pain 8
4/12/22 9:29 am pain 9
4/13/22 8:07 am pain 7
4/14/22 7:40 am pain 7 and 3:30 pm pain 7
4/15/22 7:44 am pain 8 and 3:50 pm pain 0
4/16/22 8:06 am pain 4 and 2:45 pm pain 0
4/17/22 4:00 pm pain 7
4/18/22 7:35 am pain 7
4/19/22 7:44 am pain 7
4/20/22 7:39 am pain 8
4/21/22 and 4/22/22 no documentation
4/23/22 7:59 pm pain 8
4/24/22 8:39 pm pain 7
4/25/22 3:15 pm pain 7
4/26/22 8:23 am pain 8 and 2:57 pm pain 8
4/27/22 7:10 pm pain 6
4/28/22 8:05 am pain 8
4/29/22 6:56 pm pain 10
4/30/22 8:03 am pain 7, 2:58 pm pain 7, 7:55 pm pain 7
5/1/22 day 7, evening and nights no documentation
5/2/22 no documentation
5/3/22 day 8, evening 6, night 4
5/4/22 day 8 (end of review)

On 05/04/22 10:57 am an interview was conducted with Resident #48. He stated that he had pain medication 2 hours ago and had pain in his feet of "5". He stated that he had 2 tablets this morning (pain medication). "My pain is not controlled." He stated that he was losing his toes, "they would fall off on their own" and the resident responded to inquiry that "my feet had numbness,

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F 697	Continued From page 48	F 697		

tingling, and stabbing pain." I had only been asked by staff my feet pain level. No one had asked me how my feet felt and I only provided the pain level when asked.

On 5/4/22 at 11:10 am an interview was conducted of the assigned Nurse #4. She stated that Resident #48 has had pain of his feet from the gangrene toes at a level of 8 with pain medication. She stated, "the resident keeps saying his pain was 8 even with medication for my shift today." The nurse practitioner recently ordered increased medication (4/19/22) every 6 hours as needed 1 tablet for pain level 1-5 and 2 tablets for pain level 6 - 10. The toes had increased pain and drainage, and the resident was given antibiotics. Medication was not to be given any more than every 6 hours.

On 5/4/22 at 11:15 am interview was conducted with Nursing Practitioner (NP) #1. She stated that the resident was evaluated for pain to his toes from the gangrene. "He is going to have pain in his toes because he has gangrene, and his gangrene toes will autoamputate. She responded that "the resident can have controlled foot pain (by use of medication)." NP #1 stated she assessed the resident for pain, was aware he was a diabetic, and he was not evaluated for diabetic neuropathy and prescribed medication. The NP stated she was not aware the resident had burning, stabbing, and tingling pain to his feet. The NP had not evaluated and prescribed medication for diabetic neuropathy and would order something.

On 5/4/22 at 11:30 am an interview was conducted with Resident #48 ' s physician. The physician stated that he was not familiar with

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F 697	Continued From page 49 Resident #48 and had not seen him since admission on 2/4/22. The physician requested and was provided the resident's history, NP assessments and orders from admission 2/4/22 to 5/4/22. The physician stated that he agreed the resident has signs and symptoms of neuropathy and should have been assessed and provided medication for the neuropathy. The physician was not aware the resident was not evaluated for diabetic neuropathy by the NP. The physician stated that the resident had no physician visit/assessment since admission, and he had not read the nurse practitioner ' s notes. On 5/4/22 NP #1 ordered Gabapentin 100 mg BID for neuropathy. On 5/5/22 at 1:40 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she was not aware Resident #48 had continued and worsening pain of his toes and that the resident ' s physician had not completed the admission assessment nor saw the resident since his admission and the physician was not aware of the resident ' s history and pain. The DON stated that Hydrocodone would not relieve diabetic neuropathy pain.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		5/31/22

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F 761	Continued From page 50 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to discard an expired medication in 1 of 2 medication refrigerators (200 hall) and failed to label 1 of 2 multidose insulin medications when opened in 1 of 2 medication carts observed for medication storage (100 hall). Findings included: 1. A review of the facility's 'Storage of Medication Requiring Refrigeration' policy with no reviewed/revised dates indicated staff should observe proper storage and labeling requirements for all medications during the performance of their daily tasks ....and remove any expired medications from active stock, and discard medication according to facility policy. An observation was done on 05/04/22 at 9:02 AM	F 761	F761 □ Label/Store Drugs and Biologicals 483.45(g)(h)(1)(2) 1. The identified expired medication in 200 hall medication refrigerator and the open multidose unlabeled insulin medication on 100 halls were discarded by the Nurse on the unit on 05/04/2022. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: All current residents have the potential to be affected. An audit will be completed by the Director of Nursing of the facility medication carts and medication storage rooms to ensure any identified expired or unlabeled medications have been discarded as required by 05/26/2022. The Licensed Nurses to include agency licensed nurses will be educated by the Director of Nursing or designee to ensure	

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F 761	Continued From page 51 of the 200 Hall Medication Storage room with Medication Aide (MA) #3. It revealed 2 open bottles of pantoprazole suspension,(a medication to reduce stomach acid) 2 milligrams/milliliter (mg/ml) stored in the refrigerator. Bottle #1 displayed a label of "DO NOT USE AFTER 4/24/22." The medication was for Resident #94 and was ordered on 03/30/22 as Pantoprazole 20mg (5 mg/5 ml)) 2 times a day. The Medication Aide stated night shift was responsible to check the medication rooms in addition to and the staff giving medications should check the expiration dates. Unit Manager #1 for the 200 hall was interviewed on 05/05/22 at 11:25 AM regarding the expired medication. She stated staff giving medications should have checked for the expiration date on the bottle and discarded it or sent it back to pharmacy when it expired. She verified that night shift was responsible to check the medication rooms as well. The Director of Nursing (DON) was interviewed on 05/05/22 at 4:41 PM about the expired medication. She stated the staff needed to check the dates before administration, and discard or send the medication back to pharmacy when expired. The DON said staff were not to leave expired medication in the refrigerator or the medication cart and were to check the dates frequently. She did not say but held each MA/nurse accountable. An interview was done on 05/05/22 at 5:16 PM with the Administrator regarding medication storage. He stated the medication storage procedures should be followed per policy and expired medications discarded.	F 761	medication carts and storage rooms are being checked for expired medications and unlabeled medication. New hires to include agency licensed nurses will be not allowed to work until the education is completed. 3. The Director of Nursing will complete audits of 5 current residents weekly for 4 weeks and monthly for 2 months to ensure medications carts and medication storage rooms are being checked for expired medications, multi-dose insulin vials and unlabeled medication, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Director of Nursing will submit the findings to the Quality Assurance and Performance Improvement Committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Completion date: 05/31/22	

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2. A review of the facility's 'Storage of Medication Requiring Refrigeration Storage' policy with no reviewed/revised dates indicated staff should observe proper storage and labeling requirements for all medications during the performance of their daily tasks .... It also included to date and label multi-use vials when the vial was first accessed. The vial should be dated and discarded within 28 days.

Review of the manufacturer's instructions for Lantus Solustar (insulin) revealed open insulin pens must be discarded after 28 days.

An observation was done on 05/04/22 at 4:38 PM of the 100 Hall nurse medication cart with Nurse #7. The Lantus Solustar 100 unit/milliliter (u/ml) insulin pen for Resident #32 was not dated with an open date or the discard date.

An interview was done with Nurse #7 on 05/04/22 at 4:38 PM and she noted the insulin should have been dated when removed from the refrigerator and expired at 28 days.

An interview was done on 05/04/22 at 4:36 PM with Unit Manager #2 for the 100 Hall. He stated the insulin multi-dose pen should be dated and the date should be written on the insulin pen when it was taken out of the refrigerator.

The Director of Nursing (DON) was interviewed on 05/05/22 at 4:41 PM regarding the insulin pen not being dated when it was removed from the refrigerator and opened. The DON said staff had been inserviced frequently by both nursing and pharmacy, to date the insulin pen when opened with the open date and expiration date. She

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F 761	Continued From page 53 stated she expected the insulin to be dated when opened. An interview was done on 05/05/22 at 5:16 PM with the Administrator regarding medication storage. He stated the medication storage procedures should be followed per policy, expired medications to be discarded and insulin pens dated per the requirements. .	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to use hand soap and hot water for hand hygiene, sanitize dishes in a high temperature dish machine using water that	F 812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary 483.60(i)(1)(2)	5/31/22

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F 812	Continued From page 54 reached a minimum temperature of 180 degrees Fahrenheit (F) for the final rinse cycle, and maintain the kitchen floor, clean, and in good repair. This failure had the potential to affect 104 of 106 residents. The findings included: 1. An initial brief tour of the kitchen occurred on 5/2/22 at 10:46 AM. During the tour, a wall mounted soap dispenser was observed without a cover and without soap. A plastic bottled dispenser with a blue liquid was observed on the hand sink. The bottle had a label that read "Wash free, Instant Hand Sanitizer." On 5/2/22 at 10:50 AM, a wall mounted dispenser was observed on the wall next to the back door. Cook #1 was observed to dispense a white foamed liquid from this dispenser and stated, "This is hand sanitizer." Cook #1 rubbed the white foamed liquid on both hands without rinsing her hands and prior to removing cooked pasta from the stove which she took to the sink and rinsed in water. Cook #1 stated on 5/2/22 at 10:51 AM that the wall mounted soap dispenser at the hand sink was broken and had been since Thursday, 4/28/22, so she asked Housekeeper #1 to provide soap and an alcohol-based hand sanitizer (ABHS) for the kitchen. Cook #1 stated she was not aware that an ABHS could not be used for hand hygiene by kitchen staff. Housekeeper #1 was interviewed on 5/02/22 at 11:20 AM and stated that she provided soap and ABHS to the kitchen on Thursday, 4/28/22 when Cook #1 told her that the wall mounted soap dispenser was broken. Housekeeper #1 stated that she placed the blue liquid in the plastic	F 812	1. No specific residents were cited. The wall mounted hand sanitizer was removed from the wall as of 05/05/2022,and individual plastic hand sanitizer bottles within the dietary department were removed as of 05/05/2022. The dish washing machine was inspected and no problems with holding temperature were found. A contractor is scheduled to complete replacement of all missing floor tiles. 2. For all residents with the potential to be affected by the alleged deficit practice, the following has been achieved: The Dietary Manager or Regional Dietary Manager to educate all dietary staff on appropriate hand washing and temperature logging for the dish washing machine. Education completed on 05/05/2022. All newly hired staff will be educated at time of hire. 3. The Dietary Manager or designee to monitor proper hand washing for dietary staff and dish washing machine temperatures 4x per week for 4 weeks, then 3x per week for 4 weeks, then 1x per week for 4 weeks, or until substantial compliance is met per the Quality Assurance and Performance Improvement Committee. 4. The Dietary Manager will bring results to our monthly Quality Assurance and Performance Improvement Committee meeting monthly to present results and take recommendations on any process improvement for a duration of three months or until the process has shown that it has improved adequately. Completion date: 05/31/22	

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F 812	Continued From page 55	F 812		

bottled dispenser and that the blue liquid was soap and not sanitizer. She stated that the wall mounted dispenser at the back door contained ABHS, with both soap and ABHS available for use, until the wall mounted soap dispenser could be replaced. She stated that both soap and ABHS were used by dietary staff for hand hygiene and that she was not aware that an ABHS could not be used for hand hygiene by kitchen staff.

The Housekeeping Director was interviewed on 5/02/22 at 11:30 AM and stated she was aware that the wall mounted soap dispenser was broken in the kitchen but that a plastic bottled soap dispenser had been provided for the kitchen until the wall mounted soap dispenser could be replaced. She stated she was not aware the soap was in a dispenser labeled as hand sanitizer. She stated she was not aware that the kitchen also had ABHS for use or that ABHS could not be used by staff in the dietary department.

The Regional Dietary Manager was interviewed on 5/5/22 at 10:18 AM and stated he had been in this role at the facility for 2 weeks. He stated he was not aware that there was a hand sanitizer dispenser in the kitchen, and stated "It should not be there, we will have it removed immediately." He stated that the dietary department should only use soap and hot water to sanitize their hands.

An interview with the Administrator occurred on 5/5/22 at 10:57 AM and revealed that dietary staff should use hot water and soap instead of ABHS for hand hygiene.

2. On 5/5/22 at 9:54 AM a label with manufacturer instructions was observed on the high temperature dish machine which read, Hot Water

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Sanitizing, wash 150 degrees F, final rinse 180 degrees F.

Dietary Aide (DA) #1 was observed on 5/5/22 for a continuous observation from 9:54 AM until 10:04 AM using the high temperature dish machine to wash 3 racks of trays. The following wash/rinse cycle temperatures were observed:
- 9:54 AM, wash 158 degrees F, final rinse 170 degrees F
- 9:57 AM, wash 158, degrees F, final rinse 170 degrees F,
- 10:04 AM, wash 158 degrees F, final rinse 170 degrees F, observed with the Regional Dietary Manager (RDM)

DA #1 was interviewed on 5/5/22 at 10:05 AM and stated that she last checked the temperature gauges of the dish machine on yesterday, 5/4/22 when she washed dishes and the wash cycle temperature reached 160 degrees F and the final rinse cycle temperature reached 180 degrees. DA #1 stated that she began washing dishes that morning, 5/5/22 and had already washed 3 carts of dirty dishes (plates and insulated dome lids/bottoms) which had been washed and stored on racks ready for use. DA #1 further stated that she typically checked the wash/rinse cycle water temperatures and recorded the temperatures after she washed a few racks of dishes because it took a while for the water temperature to come up. An observation of storage racks revealed 136 plates, 60 insulated dome lids, and 60 insulated plate bottoms were stored ready for use.

Review of the facility's Dishwashing Machine Form for April 2022 - May 2022, recorded wash/rinse cycle temperatures for breakfast, lunch, and supper, that ranged from 158 - 165

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degrees F for the wash, and 180 - 190 degrees F for the final rinse. The initials for DA #1 were recorded next to wash/rinse cycle temperatures for 4/3/22 - 4/30/22, and 5/1/22 - 5/4/22. There were no temperatures recorded for 5/5/22.

The RDM was interviewed on 5/5/22 at 10:18 AM and stated he had been in this role at the facility for 2 weeks. He stated that the dish machine was replaced with a new dish machine in July 2022 and was serviced 2 weeks ago. He stated that the dietary staff should allow the hot water in the dish machine to reach manufacturer recommendations for wash/rinse cycle temperatures before washing dishes.

An interview with the Administrator occurred on 5/5/22 at 10:57 AM and revealed that dietary staff should wash dishes correctly in the correct temperatures.

3. An initial brief tour of the kitchen occurred on 5/2/22 at 10:46 AM with follow up observations on 5/4/22 at 12:17 PM, and 5/5/22 at 9:44 AM. During each observation the kitchen floor was observed with a build-up of debris, broken/missing floor tiles and greyish colored water pooled in the areas of the broken/missing floor tiles.

Dietary Aide (DA) #2 was interviewed on 5/5/22 at 9:58 AM and stated she started her employment at the facility in September 2021 and that she had observed the floor with broken/missing floor tiles and standing water for as long as she had been there.

Cook #1 stated in an interview on 5/5/22 at 10:00 AM that she was on leave from September 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(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 812	Continued From page 58	F 812		

until December 2021 but that the floor had missing/broken floor tiles since before September 2021. Cook #1 stated that the floor was difficult to keep clean because dirt and build up collected in the water when the floor was swept/moped in the areas where the tiles were missing/broken. Cook #1 stated that the facility had a new Maintenance Director who started in April 2022, and he was aware of the condition of the kitchen floor.

DA #1 was interviewed on 5/5/22 at 10:05 AM and stated that she worked in the dietary department since February 2022 and had observed the floor with pooled water and broken/missing floor tiles since she started her employment.

The Regional Dietary Manager (RDM) was interviewed on 5/5/22 at 10:18 AM and stated he had been in this role at the facility for 2 weeks and saw the condition of the floor with water pooling in the kitchen when he started. The RDM stated that he reported this to the Administrator so that the floor could be maintained clean and in good repair. He stated he was not aware of the plan to replace/repair the broken/missing tiles.

The Maintenance Director was interviewed on 05/05/22 at 10:22 AM and stated that when he started 3 weeks ago, there were 20 broken/missing floor tiles in the kitchen, and water pooled in these areas which caused dirt to collect in the water on the floor. He stated this made it difficult to keep the floor clean. The Maintenance Director stated he advised the Administrator of the condition of the floor and told him that the floor needed to be repaired soon. He stated that he was not aware of plan to replace/repair the floor tiles in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 59 An interview with the Administrator occurred on 5/5/22 at 10:57 AM and revealed that he was aware that the floor tiles in the dietary department were missing/broken causing water to collect in these areas. He stated that the facility had been without a Maintenance Director, and that since the position was filled 3 weeks ago the facility was trying to take care of things as quickly as possible.	F 812		