STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 unannaounced Recertification and Complaint survey was conducted 5/9/2022 to 5/16/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IQJF11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted 5/9/2022 to 5/16/2022. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity of J. The tag F689 consituted Substandard Quality of Care. Immediate Jeopardy began on 3/17/2022 and was removed on 5/16/2022. An extended survey was conducted. During the recertification and complaint investigation 7 intakes with 15 allegations, NC00185774, NC00181649, NC00188912, NC00187537, NC00172156, NC00180214, and NC00172156, were investigated and 8 of the 15 allegations were substantiated. Event ID # IQJF11.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to have briefs available for a resident (Resident #10) and failed	F 558	Regarding the alleged deficient practice of failure to provide services in the facility with reasonable accommodation of	5/27/22

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

Electronically Signed | 06/10/2022

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F 558	Continued From page 1 to provide the correct size of brief for a resident (Resident #82) for 2 of 5 sampled residents reviewed for accommodation of needs. The findings included: 1. Resident #10 was admitted to the facility on 1/6/22. Review of Resident #10's quarterly Minimum Data Set (MDS) revealed resident was cognitively intact and was always incontinent of bowel and bladder. On 5/12/22 at 11:55AM an interview with Resident #10 revealed last Wednesday (5/4/22) there were no briefs available for the staff to use to get him up. Resident #10 revealed the staff left on the old brief from the night shift and placed pads underneath him. He further revealed it was around 2:30PM before he was gotten up out of bed. Resident #10 was complementary of the facility and stated they were doing the best they could. The interview further revealed 5/4/22 was the first time this had occurred for Resident #10. An interview conducted on 5/12/22 at 10: 59AM with NA #11 revealed when she came in last week on Wednesday (5/4/22) and there were only bariatric briefs available. She stated the 11:00PM-7AM shift had reported there were no briefs. She stated that the Unit Manager #1 was sent to get the briefs and she received brief around 1:40PM that day. She further revealed that Resident #10 was one of the residents that did not have briefs available, but she put pads underneath him until the briefs were available. NA # 11 revealed she received briefs around 1:40PM that day and the resident was gotten up out of	F 558	resident needs as evidenced by: a. failure to have briefs available for resident #10 b. failure to provide the correct size of a brief for resident #82 Residents #10 and #82 were placed in proper fitting briefs on 5/4/22. The facility determined that all residents that use briefs have the potential to be affected by the alleged deficient practice. All residents that use briefs were audited on 5/27/22 to ensure they were in the correct size, no other residents were affected. The Administrator and supply clerk were in-serviced by the Chief Operating Officer on 5/17/22 regarding the need to always have the proper quantity and size briefs available to meet resident needs. Weekly supply orders of briefs will be increased to ensure that an adequate supply of all sizes of briefs are always on hand. The supply clerk will submit brief orders weekly and as needed. A backstock of briefs in all sizes was established for use as needed on demand. The supply clerk will monitor the brief inventory 3 times a week for 6 weeks and then once weekly until substantial compliance is achieved or as determined by the quality assurance team to ensure an adequate supply of briefs is available. If inventory levels fall below established par levels, a new order will be placed. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

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F 558	Continued From page 2	F 558		

bed.

2. Resident #82 was admitted to the facility on 8/17/21.

Review of Resident #82's quarterly Minimum Data Set (MDS) assessment dated 3/26/22 revealed the resident's cognition was intact and was continent of bowel and bladder.

An interview with Resident #82 on 5/13/22 at 9:47AM revealed one day last week there was an issue with briefs. She stated she was not sure what day it was, but the staff informed her they were waiting on the truck to come in and there were no briefs. She further stated she had to remain in her brief until they found some and then placed her in a brief that was too large, and urine was running down her leg. Resident #82 noted that later that same day the facility obtained the correct size brief for her. She stated the facility seems to run out of briefs often. Resident #82 also made the statement that she really had no complaints, and they do what they can.

An interview with NA# 12 on 5/13/22 at 1:04PM revealed the facility was out of briefs when she came in on the 7:00AM-3:00PM shift on 5/4/22. She further revealed she went to look in central supply and there were not any available. She stated she found a 2XL brief and placed it on Resident #82. She further revealed that Resident #82 needed extra-large briefs, but none was available. She stated she was not aware if the resident was voiding around her brief. NA #12 revealed that the facility was able to provide briefs for the resident later the same day.

An interview conducted on 5/10/22 at 2:29PM

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with Central Supply Staff Member revealed she ordered supplies on Monday. She further revealed that running out of briefs had been an issue since changing companies in January 2022. She stated that she may order what was needed but after the order went through the approval process, she would receive half of what was ordered. She stated that there was a back-up pharmacy they could order from, and a local facility would lend us supplies until the truck arrives.

The Central Supply Staff Member was unable to provide any additional follow up interview information as she was out the facility on leave after 5/10/22.

An interview conducted on 5/10/22 at 3:45PM with Unit Manager #1 revealed back in February 2022 the facility had only medium, large, and extra-large briefs. She further revealed last week on Wednesday 5/4/22 she came to the facility at 5:30AM. She stated the 11PM-7AM shift immediately reported they could not change two to three residents on 100 hall and two residents on the 200-hall because there were no briefs available. She stated she further inquired when the last time the 11:00PM-7:00AM staff were able to make rounds with briefs and was told it was between 2AM-3AM. She further stated they searched the supply room and every closet in the building and no briefs were available. She stated she notified Central Supply and she started working on trying to get some briefs. She stated that around 11:30AM she was sent by central supply to a local facility and was given 5 boxes of briefs. She further stated that the only sizes she received was two boxes of medium, two boxes of large, and one box of extra-large.

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An interview conducted on 5/12/22 at 10:48AM with NA # 8 revealed last week she reported to Unit Manager #1 that one of her residents did not have any briefs. She further revealed Unit Manager #1 was sent to get some that day. She stated that at least three of her residents did not have on the correct size brief that one day because they are not available. She stated we seem to run out more lately.

On 5/10/22 at 3:12PM an interview was conducted with NA #9. She revealed the facility ran out of briefs frequently. She stated since the new company took over the system was different and had caused them to run out of briefs. She further stated when we get low on briefs, they do ration the briefs out and give us just a few.

An interview conducted on 5/11/22 at 1:29PM with Nurse #7 revealed the facility ran out of briefs frequently. She further revealed last Wednesday (5/4/22) and Thursday (5/5/22) there was a problem with the briefs sizes in the facility that were available not fitting the residents. Nurse #7 did not name specific residents that were provided the wrong size brief.

An interview was conducted on 05/12/22 at 4:09PM with the Director of Nursing (DON) revealed she received a text message last week from the facility stating they were running low on briefs. She further revealed she was not aware that there were no briefs in the facility and that only a few sizes were available after briefs were obtained by the Central Supply Staff Member. The DON stated they should maintain a par level of briefs and she should be notified by the central supply if they got down to a few packs. The DON

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F 558	Continued From page 5 stated the central supply places the orders and if the staff cannot find briefs, they should go look for them. She further stated they should not wait until we have none in the building, as this is not acceptable. On 05/12/22 at 4:02PM an interview was conducted with the Administrator. He revealed he was not aware that facility was without briefs. He stated this should have been brought to his attention. He further revealed the facility should have as many supplies ordered as needed. He stated we have a way to get back-up supplies if needed.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		5/18/22

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F 584	Continued From page 6 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility: 1) failed to ensure floors were clean in 2 of 8 resident rooms (Room #409, Room #408); 2) failed to clean 2 of 8 shared bathrooms (Room #409, Room #411) and (Room #413, Room #415); 3) failed to maintain a homelike environment in 1 of 8 resident room (Room #409) by not cleaning fall mat observed with a large amount of dried white substance; 4) failed to ensure walls were clean in 2 of 8 resident rooms (Room #408, Room #412); 5) failed to maintain a clean and safe environment by failure to maintain drywall on the walls without holes or scratches into the drywall for 2 of 2 resident rooms (Room #411A and Room #104A); 6) failed to maintain safe conditions, when an electrical outlet did not have a cover (Room #409A) and a call light had a half-cracked cover exposing wires (Room #120) for 2 of 2 rooms reviewed for safe conditions; 7)	F 584	Regarding the alleged deficient practice of failure to provide a safe, clean and homelike environment as evidenced by: a) Failure to provide clean floor, bathroom, fall mat and wall b) Failure to maintain drywall without large holes c) Failure to have a cover on electrical outlet or call light box d) Failure to maintain cleanliness of wheelchairs On May 17, 2022, the housekeeping staff cleaned the floors in room 409 and room 408; cleaned the bathrooms in room 409, room 411, room 413 and room 415; cleaned the fall mat in room 409; cleaned the walls in room 408 and room 412; cleaned the wheelchairs of resident 32 and resident 57. On May 17, 2022, the	

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F 584	Continued From page 7 failed to provide 2 of 3 residents (Resident #32 and Resident #57) with clean wheelchairs. Findings included: 1. An observation of Room #409 was conducted on 05/09/22 at 11:05AM. Observation revealed five areas of brown circular dried substance noted to the floor. The dried substance was in the middle of the floor, and this room was occupied with residents. Subsequent observations conducted on 05/10/22 at 9:07AM, 05/10/22 at 5:05PM, and 05/11/22 at 10:15 AM revealed the conditions remained unchanged. An interview and observation of Room #409 with Maintenance Director on 5/12/22 at 9:00AM revealed the areas to the floor should have been cleaned by housekeeping. The Maintenance Director scraped the floor and the brown substance observed to be removed off the floor. The Maintenance Director stated housekeeping could get a razor and remove the substance off the floor. An interview and observation of Room #409 with the Housekeeping Director on 5/12/22 at 9:15AM revealed floor should be cleaned daily. She further stated the facility had tried to get the brown substance off the floor, but it would not come up. The Housekeeping Director stated that she was going to get something to try to scape it up. An interview with the Administrator on 5/12/22 at 3:55PM revealed the rooms should be cleaned daily, and the housekeeping director should be doing audits everyday to ensure rooms are cleaned.	F 584	Maintenance Director repaired the drywall holes and scratches in room 411 and room 104; replaced the electrical outlet cover in room 409 and replaced the call light cover in room 120. Facility resident rooms, bathrooms and wheelchairs were audited by the Maintenance Director and Housekeeping Supervisor for cleanliness, large holes in walls, broken electrical outlet covers and call light cord wall covers, with follow-up per findings. On May 18, 2022, the Maintenance Director and Housekeeping Supervisor were in-serviced regarding safe and sanitary home like environment, as well as expectations and proper procedures for maintaining the environment which includes wheelchair cleaning and room deep cleans on a repeating schedule, and weekly facility rounds to identify needed repairs. Administrator (NHA) or Maintenance Director will conduct random audits of resident rooms for wall damage, broken outlet and call light covers per the following schedule: 5 rooms per week for 4 weeks, then 3 rooms per week for four weeks. NHA or Housekeeping Supervisor will conduct random audits of resident rooms and bathrooms, to include floors and fall mats, and wheelchairs, for cleanliness per the following schedule: 5 rooms per week for 4 weeks, then 3 rooms per week for four weeks. NHA will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance.	

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F 584	Continued From page 8 b. An observation of Room #408 was conducted on 5/09/22 at 3:50PM. Observation revealed on the bathroom floor dried green substance noted to floor and crown molding. An interview and observation of Room #408 with the Housekeeping Director on 5/12/22 at 9:17AM revealed green substance remained on the floor and on the crown molding. The Housekeeping Director further revealed the housekeeper should have checked the floor and cleaned daily. An interview with the Administrator on 5/12/22 at 3:55PM revealed the rooms should be cleaned daily, and the housekeeping director should be doing audits every day to ensure rooms are cleaned. 2. An observation of Room #409/ #411 shared bathroom was conducted on 05/9/22 at 11:05 AM. Observation revealed strong odor of urine and brown substance around the base of the bottom of the toilet. Subsequent observations conducted on 05/10/22 at 9:07AM, 05/10/22 at 5:05PM, and 05/11/22 at 10:15 AM revealed the conditions remained unchanged. An interview and observation of Room #409 with the Housekeeping Director on 5/12/22 at 9:15AM revealed the bathroom should have been cleaned. She further stated the facility had tried to get urine odor out of the bathroom, however they had been unsuccessful due to four men sharing the bathroom. The Housekeeper Director stated she tried to get up the brown substance around the toilet rim yesterday with a broom but was unable to get it up.	F 584	NHA will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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An interview with the Administrator on 5/12/22 at 3:55PM revealed the rooms should be cleaned daily, and the housekeeping director should be doing audits every day to ensure rooms are cleaned.

b. An interview with Resident #45 in Room #413 on 5/9/22 at 11:38AM revealed her shared bathroom needed cleaning. She further indicated that fecal matter was on her toilet and had been there for a few days. She further indicated that her bathroom was not cleaned yesterday at all.

An observation on 5/9/22 at 12:07PM revealed large area of brown substance to the back of the removeable bedside commode container. Subsequent observations conducted on 5/10/22 at 9:13AM, and 5/10/22 at 4:52PM revealed conditions remained unchanged.

An interview and observation of Room #413 with the Housekeeping Director on 5/12/22 at 9:15AM revealed toilet should have been cleaned daily. She further revealed she cleaned it yesterday afternoon on 5/11/22.

An interview with the Administrator on 5/12/22 at 3:55PM revealed the rooms should be cleaned daily, and the housekeeping director should be doing audits every day to ensure rooms are cleaned.

3. An observation of Room #409 was conducted on 05/9/22 at 11:05 AM. Observation revealed large areas of dried white matter on floor fall mat beside of the resident's bed (Resident # 88). Subsequent observations conducted on 05/10/22 at 9:07AM, 05/10/22 at 5:05PM, and 05/11/22 at

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10:15 AM revealed the conditions remained unchanged.

An interview was conducted on 5/11/22 at 10:56AM with housekeeping director that revealed the housekeeping department is responsible for sweeping, mopping, cleaning the resident rooms, bathrooms, around the toilets, and cleaning fall mats at the bedside.

On 5/12/22 at 9:15am an interview and observation of Room #409 with the Housekeeping Director revealed that it appeared to be milk stains on the floor mat and should have been cleaned. She further revealed she cleaned it yesterday (5/11/22) after our interview.

An interview with the Administrator on 5/12/22 at 3:55PM revealed the rooms should be cleaned every day, and the housekeeping director should be doing audits every day to ensure rooms are cleaned.

4. An observation of Room #408 was conducted on 5/09/22 at 3:50PM. Observation revealed on the bathroom wall beside the sink a vertical area of dried green matter. A further observation in Room 412A on 5/10/22 at 4:47PM revealed splatters of brown matter against the wall by the resident's bed. Subsequent observations conducted on 5/11/22 at 10:16AM and 5/12/22 at 9:15AM revealed conditions remained unchanged.

On 5/12/22 at 9:15am an interview and observation of Room #408 and Room 412A with the Housekeeping Director revealed the walls should have been checked during the room cleaning, and housekeeper should have wiped

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the wall down.

5. An observation on 5/9/22 at 11:33AM in Room # 411A revealed wall beside the right side of the bed with large area of damaged and scratched drywall. Subsequent observations conducted on 5/10/22 at 4:57PM revealed conditions remained unchanged.

On 5/12/22 at 9:05AM an observation and interview with the Maintenance Director revealed the area to Room # 411A may have come from the wheelchair. He further revealed the staff should have place the repairs needed in the book at the nurses' station. The maintenance director stated this area should have been patched and painted and it was his responsibility.

An interview with the Administrator on 5/12/22 at 3:55PM revealed the staff should have placed the areas of needed repairs in the log at the nurses' station. He further revealed the Maintenance Director should be making rounds to check for needed repairs.

6. An observation on 5/9/22 at 10:43AM revealed no cover on a two-prong outlet in Room #409 on the side of Resident #88 bed. Subsequent observations conducted on 5/10/22 at 9:07AM, 5/10/22 at 5:04PM and 5/11/22 at 10:15AM revealed conditions remained unchanged.

On 5/12/22 at 9:05AM an observation and interview with the Maintenance Director of Room # 409 revealed the staff should have place the repairs needed in the book at the nurses' station. The maintenance director stated this was his responsibility and should have been replaced immediately.

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An interview with the Administrator on 5/12/22 at 3:55PM revealed the staff should have placed the areas of needed repairs in the log at the nurses' station. He further revealed the Maintenance Director should be making rounds to check for needed repairs

6).
b. An observation on 5/9/22 at 11:34 AM of room 104-A was completed. Two people occupied room 104 revealed the wall on the A side had visible damage to the drywall exposing the sheet rock which was behind the resident's bed.

A tour was completed with the Maintenance Manager (MM) on 5/12/22 at 3:51 PM of room 104-A. The MM stated that he had not seen this large hole before which was identified as being approximately five by eight inches.

A review of the Maintence logs from November 2021 to May 12th, 2022, revealed no maintenance requests had been filled out for room 104 A regarding a hole in the wall.

A second interview was completed with the MM on 5/13/22 at 12:26 PM who stated that he had repaired a lot of drywall holes with patches in several resident rooms, but this was the first time he had saw this hole. The MM stated that anyone can fill out a maintenance request which is kept in a book at the nurse's station.

7). An observation was completed on 5/9/22 at 12:45 PM of room 120 which revealed a call light plate approximately four by five inches mounted to the wall had half of the cover missing with

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exposed wires. The wire led to another modernized call light mounted directly above the older call light plate. The call light was operational and turned on when the call light button was pressed.

An interview was completed with Resident #37 during the observation on 5/9/22 who was asked how long the call light plate had been broken. She stated that it had been that way since she had moved in.

A tour was completed with the Maintenance Manager (MM) on 5/12/22 at 3:51 PM of room 120 to observe the call light cover that was cracked and had wires exposed. The MM stated he was not aware of the call light cover being cracked halfway off and that it did need to be replaced.

A review of the Maintence logs from November 2021 to May 12th, 2022, revealed no maintenance requests had been filled out for the call light cover being cracked off.

A second interview 05/13/22 12:26 PM was completed with the MM who stated that the wires that were exposed was sealed and did not have any damage to the wires. He stated that he checks the call lights for the entire building one time a month. The MM stated that he did not notice the call light to have a cracked cover.

On 5/13/22 at 3:47 PM an interview was completed with the Administrator who stated we do try and repair these things immediately as they come up and we will continue to keep on things.

8. Resident #32 admitted to the facility on 3/15/2022, he discharged to the hospital on

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4/18/2022 and readmitted on 4/25/2022.

The most recent Minimum Data Set (MDS) Assessment dated 2/24/2022 revealed Resident #32 was cognitively impaired and required extensive assistance with transfers and mobility in the facility.

An observation was made of Resident #32 on 5/11/2022 at 6:08 pm and his wheelchair had dried food particles and a dark brown substance on the armrests and the metal bars under his wheelchair seat. There were also food particles in the wheelchair seat.

On 5/12/2022 at 1:44 pm Resident #32 was observed up in his wheelchair. Resident #32's wheelchair continued to have food particles in the seat and the armrests and metal under the wheelchair continued to have a dark brown substance on the armrests and the metal bars under his wheelchair seat.

An interview on 5/11/2022 at 6:21 pm with Resident #32's Family Member revealed he visited daily, and he stated he took Resident #32's wheelchair home with him and pressure washed it a month ago, but it usually looked like it does right now with the brown substance on the armrests and metal under the seat and food particles in the seat. The Family Member stated he would like for the wheelchair to be kept clean.

During an interview with the Housekeeping Manager on 5/12/2022 at 1:52 pm she stated she washed Resident #32's chair when he came back from the hospital on 4/25/2022. She stated she does have a schedule for cleaning the resident's wheelchairs, but she had not been able to follow

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the schedule because she had been short staffed in housekeeping.

On 5/12/2022 at 2:19 pm the Housekeeping Manager brought a list of wheelchairs she cleaned on 4/10/2022 and Resident #32 was on the list.

The Administrator was interviewed on 5/13/2022 at 2:05 pm and stated all resident wheelchairs should be cleaned every 30 days and as needed to keep them clean. He stated the housekeeping staff should be documenting the wheelchairs being cleaned on an audit form. The Administrator stated he was not aware the wheelchairs were not being cleaned as scheduled and as needed.

9. Resident #57 admitted to the facility on 2/3/2019 with diagnoses of cancer and dementia.

A Minimum Data Set (MDS) Assessment dated 3/10/2022 indicated Resident #57 was cognitively intact and required supervision with transfers and mobility.

The Housekeeping Manager was interviewed on 5/12/2022 at 1:54 pm and she stated she has not been able to keep the schedule of cleaning the resident's wheelchairs monthly because she is short staffed.

On 5/12/2022 at 1:40 pm an observation of Resident #57 revealed he had dried food particles on the armrests and on the metal bars below the seat of his wheelchair. Resident #57 said he does not remember his wheelchair being cleaned and stated he would like for the wheelchair to be cleaned.

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F 584	Continued From page 16 The Administrator was interviewed on 5/13/2022 at 2:05 pm and stated all resident wheelchairs should be cleaned every 30 days and as needed to keep them clean. He stated the housekeeping staff should be documenting the wheelchairs being cleaned on an audit form. The Administrator stated he was not aware the wheelchairs were not being cleaned as scheduled and as needed.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		6/13/22

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F 636	Continued From page 17 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility failed to complete a comprehensive admission Minimum Data Set (MDS) by the 14th calendar day of admission to the facility for 1 of 3 residents reviewed for timely completion of	F 636	Regarding the alleged deficient practice of failure to submit comprehensive assessments per the timeframe prescribed as evidenced by: a) Failure to submit comprehensive	

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F 636	Continued From page 18 comprehensive MDS assessments (Resident #80). Findings included: Resident #80 was admitted to the facility on 3/23/22 with diagnoses that included end stage renal disease (ESRD) and hemodialysis. Review of an admission comprehensive Minimum Data Set (MDS) dated 3/30/22 revealed that the MDS was signed and dated as completed on 4/13/22, 22 days after Resident #80's admission. On 05/13/22 at 1:22 PM an interview conducted with MDS Nurse #1 revealed that she was aware that the comprehensive admission MDS for Resident #80 was completed late because she had been working without assistance for at least 3 months and was not able to complete her work timely.	F 636	admission assessment for resident #80 within prescribed timeframe. Assessment was submitted on 04/13/2022 after admission on 03/23/2022. On 06/02/2022, Regional Nurse Consultant provided re-education for facility Minimum Data Set (MDS) Department regarding Resident Assessment Instrument (RAI) requirements including completion of comprehensive assessments. On 06/10/2022, Director of Nursing audited current resident comprehensive MDS admission assessments to ensure completion and submission. No pending or overdue comprehensive admission assessments identified. Director of Nursing (DON) or Assistant Director of Nursing (ADON) to complete auditing of current residents to ensure comprehensive MDS Admission Assessments completed timely per requirements per the following schedule: 10 resident assessments per week x 4 weeks, then, 3 assessments per week x 4 weeks, then, 3 assessments monthly x 2 months. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/9/22

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F 641	Continued From page 19 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, and observations the facility failed to correctly code Minimum Data Set (MDS) assessments in the areas of dialysis (Resident #80), and range of motion (Resident #84) for 2 of 21 residents reviewed for MDS accuracy. 1.Resident #80 was admitted to the facility on 3/23/22 with diagnoses that included end stage renal disease (ESRD) and hemodialysis. A review of the medical record for Resident #80 included a physician order dated 3/23/22 the Resident #80 was to receive hemodialysis 3 days a week, every Tuesday, every Thursday, and every Saturday. Review of an admission comprehensive Minimum Data Set (MDS) dated 3/30/22 revealed that the section O0100 J was not coded to include that Resident #80 received dialysis while residing in the facility. On 5/13/22 at 1:22 PM an interview conducted with MDS Nurse #1 revealed that she was aware that Resident #80 received dialysis 3 days a week since admission and that she had not coded dialysis on the MDS as an oversite on her part. 2. Resident #84 was admitted to the facility on 12/5/17 with diagnoses that included contracture of right hand, rheumatoid arthritis and hemiplegia	F 641	Regarding the alleged deficient practice of failure to submit assessment that accurately reflects residents' status as evidenced by: a) Failure to correctly code Minimum Data Set assessment to reflect dialysis services, b) Failure to correctly code limited range of motion to bilateral upper extremities. On 05/13/22 and 06/02/22 respectively, Minimum Data Set (MDS) assessments were amended by the Registered Nurse MDS Coordinator to correct the noted areas of dialysis (#80) and bilateral limited range of motion (#84). All residents receiving dialysis services and all residents with limited range of motion have the potential to be affected. An audit was conducted by the Director of Nursing on 06/02/2022 of MDS assessments submitted in May for current residents receiving dialysis services & restorative services for limited range of motion to ensure accurate coding. MDS nurse was educated on 06/09/2022 by Corporate Nurse Consultant regarding accurate assessment and coding of dialysis services and limited/impaired range of motion. Director of Nursing (DON) or Assistant Director of Nursing (ADON) will audit 100% of dialysis residents and 5 residents	

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F 641	Continued From page 20 affecting the right dominant side. Review of the Resident #84's care plan dated 3/29/22 revealed an ADL care plan which noted limited range of motion with contracture to right hand only with interventions to break up task into smaller steps. An observation on 5/09/22 at 3:15 PM of Resident #84 revealed both hands to have limited range of motion and contracted. Review of the quarterly Minimum Data Set (MDS) dated 3/28/22 revealed limited range of motion to upper extremities and was coded only to one side. On 5/12/22 at 1:33 PM an interview conducted with MDS Nurse #1 revealed that it had been a while since she assessed Resident #84. She further revealed both of Resident # 84 hands were contracted. MDS Nurse #1 stated that the MDS was only coded for one side, and it was a coding error on the MDS and an oversite on her part. An interview conducted on 5/12/22 at 1:42PM with Occupational Therapist #2 revealed Resident #84 was not currently on caseload. She further revealed Resident #84 was contracted on both sides and her right upper extremity is worse than her left upper extremity. She stated Resident # 84 had been discharged on 10/21/21 and was not on restorative as she had refused. On 5/13/22 at 3:47 PM an interview was completed with the Administrator who stated that the MDS should be accurate and portray the current resident status comprehensively.	F 641	receiving restorative services for range of motion every week for 4 weeks for accurate coding of dialysis services and limited range of motion. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan within 21 days after admission for 1 of 6 residents reviewed for comprehensive care plan completion (Resident #80). Findings included:	F 657	Regarding the alleged deficient practice of failure to develop a comprehensive care plan within 21 days of admission as evidenced by: Resident 80 admitted on 03/23/2022 with comprehensive care plan was completed on 22nd day of stay, 04/13/2022. On 06/02/2022, Regional Nurse	6/9/22

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F 657	Continued From page 22 Resident #80 was admitted to the facility on 3/23/22 with diagnoses that included end stage renal disease (ESRD) and hemodialysis. Review of an admission comprehensive Minimum Data Set (MDS) dated 3/30/22 revealed the MDS was signed and dated as completed on 4/13/22. The comprehensive care plans for Resident #80 were signed as completed 4/13/22. On 05/13/22 at 1:22 PM an interview was conducted with MDS Nurse #1. She revealed she was aware that Resident #80's comprehensive care plans had not been completed within the regulated time frame. MDS Nurse #1 explained she had been working without assistance for at least 3 months and she was behind and not able to complete her work timely.	F 657	Consultant provided re-education for facility Minimum Data Set (MDS) Department regarding Resident Assessment Instrument (RAI) requirements including timing and completion of comprehensive care plans. On 06/08/2022, Director of Nursing (DON) audited all residents admitted within past 3 months for completion of comprehensive care plans; all have a completed comprehensive care plan. DON or Assistant Director of Nursing (ADON) to complete auditing of newly admitted residents to ensure comprehensive care plans are completed within 21 days per the following schedule: 3 newly admitted residents per week x 4 weeks, then, 3 residents per week x 4 weeks, then, 3residents monthly x 3 months. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff	F 677	Regarding the alleged deficient practice	6/13/22

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F 677	Continued From page 23 interviews the facility failed to provide nail care for 1 of 6 residents, Resident #42, who was dependent for personal care. Findings included: Resident #42 was admitted to the facility on 8/2/2017 with diagnoses of dementia and stroke. An annual Minimum Data Set (MDS) assessment dated 3/1/2022 indicated Resident #42 was severely cognitively impaired and required extensive assistance with personal care. Review of Resident #42's medical record revealed the Social Worker's progress note dated 5/3/2022 at 12:32 pm stated the Family Member had requested Resident #42's toenails be assessed, and nail care provided. The Social Worker's progress note further stated she informed Unit Manager #2 of the Family Member's request by email. During an interview and observation of Resident #42's toenails with Nurse #5 on 5/12/2022 at 2:46 pm a red area was noted to the lateral side of the second toe on her right foot. Nurse #5 stated the area was caused by Resident #42's great toe toenail rubbing the side of her second toe and the great toe toenail was approximately one half inch long and jagged. Nurse #5 stated Resident #42 is not diabetic and the Nurses or Nurse Aides can trim her toenails. She stated the resident's toenails are usually trimmed when they are showered and whenever they need it. Nurse #5 stated all residents have a skin assessment weekly and their feet are checked during the assessment and their toenails should be trimmed when needed. Nurse #5 stated she was not	F 677	of failure provide nail care for a resident who was dependent for personal care as evidenced by: Resident #42 toenail approximately one half inch long and jagged On 05/13/2022, Resident #42's nails were assessed by the unit coordinator, and a podiatrist appointment was made for 05/19/2022. The resident attended this appointment. On 06/09/2022, the Director of Nursing (DON) & Assistant Director of Nursing (ADON) completed an assessment of all resident nails with appropriate follow-up per findings. On 06/10/2022, DON & ADON provided inservice education to nursing staff regarding nail care, to include specialized conditions and resident preferences, education to continue for nursing staff upon return to work, to be completed by 06/13/2022. DON, ADON, or treatment nurse will conduct random audits of all residents who are dependent for nail care per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 677	Continued From page 24 aware Resident #42's Family Member had asked for her toenails to be assessed and nail care provided. An interview was conducted with Unit Manager #2 on 5/13/2022 at 10:21 am and she stated she was not aware Resident #42's Family Member had requested her toenails be assessed and nail care provided. Unit Manager #2 stated the request should have been reported to the nurse or Unit Manager on duty as soon as the request was made. Unit Manager #2 was unable to explain why staff had not identified the need for nail care when Resident #42's toenails were observed during the weekly skin assessment and during her recent showers. The Director of Nursing (DON) was interviewed on 5/13/2022 at 10:26 am and stated Resident #42's toenails should be assessed during her skin assessment which is done weekly. The DON stated the nurse should trim a resident's nails and toenails when needed unless it needs to be done by the podiatrist. The DON also stated the Family Member's request for Resident #42's toenails to be assessed and nail care provided should have been reported to the nurse immediately. On 5/13/2022 at 1:58 pm an interview was conducted with the Administrator, and he stated any resident care issue should be reported to the nurse immediately and followed up on immediately.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		6/3/22

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F 684	Continued From page 25 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to apply bilateral palm protectors as ordered for 1 of 3 residents reviewed for positioning (Resident #84). The findings included: Resident #84 was admitted to the facility on 12/5/17 with diagnoses that included contracture of right hand, rheumatoid arthritis and hemiplegia affecting the right dominant side. Review of Resident # 84's most recent quarterly Minimum Data Set (MDS) dated 3/28/22 revealed she was cognitively intact for daily decision making and required limited to extensive assist with activities of daily living (ADL). Review of Resident #84's care plan dated 3/29/22 revealed care plan goal for resident to remain free from pressure-related skin breakdown with intervention to apply palm protectors as ordered. Review of Resident #84's physician orders dated 9/27/21 revealed order for third shift to apply bilateral palm protectors at the beginning of every night shift for skin integrity. Further review of physician's order revealed order dated 9/27/21 first shift to remove bilateral palm protectors at the beginning of shift.	F 684	Regarding the alleged deficient practice of failure to ensure residents receive treatment and care in accordance with professional standards of practice as evidenced by: Failure to apply bilateral palm protectors per order and care plan On 06/02/2022, Resident #84 TAR was updated to reflect order for palm protectors to ensure documentation of application. Resident's Kardex was also updated to include use of palm protectors. On 06/03/2022, all residents were reviewed for palm protector orders to ensure appropriate documentation and application. New palm protector orders will be monitored weekly to ensure appropriate transcription to MAR or TAR, as well as to validate application. Unit Coordinators and/or Shift Supervisors will observe resident care daily for one week for those residents requiring the use of palm protectors to ensure proper and consistent application. Thereafter, residents will be monitored three times per week for four weeks to assure proper and consistent use. DON or ADON will review the audits monthly to identify patterns and trends	

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F 684	Continued From page 26 Review of Resident #84's April 2022 and May 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no order or documentation for application or removal of bilateral palm protectors. Review of Resident #84's Kardex (Nurse Aide guide to resident care) revealed no intervention of application or removal of bilateral hand protectors. Interview with Resident #84 on 5/11/22 at 10:09AM revealed the palm protectors were in the second drawer next to her bed. She further revealed that she was the one that put-on the palm protectors. She stated she would try to put them on at bedtime whenever she would remember to do so. Interview with Nurse #7 on 5/11/22 at 1:38PM revealed he was unaware of the physician's order for bilateral palm protectors to be placed on Resident # 84 at bedtime. Interview with NA #5 at 8:52AM on 5/12/22 revealed she worked third shift and was assigned to Resident #84. She further revealed that she was not aware of any interventions to place bilateral palm protectors on at bedtime. She stated that usually if there was a change that the NA's need to be aware of it is passed on in report from the prior shift. On 5/12/22 at 10:59AM an interview with NA #11 revealed she was assigned to Resident #84 on the day shift. She further stated she had not witnessed Resident #84 with bilateral palm	F 684	and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 684	Continued From page 27 protectors on when she arrived on her shift and was unaware of the intervention for bilateral palm protectors. An interview on 5/12/22 at 12:26PM with NA #3 revealed she was assigned to Resident #84 two or three times a week. She further revealed she was unaware of an intervention to apply palm protectors on Resident #84 at bedtime. Interview with Nurse Aide (NA) #6 on 5/13/22 at 12:17PM revealed she was assigned to Resident #84 on the 7:00 AM to 3:00 PM shift, and she had not removed palm protectors, or was not aware of any instructions about removing palm protectors. She further stated Resident #84 would not have on palm protectors at the beginning of her shift. On 5/12/22 at 4:09PM an interview with the Director of Nurses (DON) revealed if there was an order for bilateral hand protectors for Resident #84 staff should put them on. She further revealed it was the nurse's responsibility to communicate any new changes or interventions to the NA's. The DON revealed the NA's should have been instructed by the charge nurses the specifics on applying and removing the palm protectors. She stated it was her expectation if there is an order that it be followed.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		5/16/22

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F 689	Continued From page 28 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview with staff, Medical Director and the Nurse Practitioner the facility failed to increase supervision of Resident #57, knowing he had a history of removing his wanderguard (a device that triggers alarms and can lock monitored doors to prevent a resident from leaving unattended) device and failed to monitor the placement of Resident #57's wanderguard. On 3/17/22, he exited the facility without staff's knowledge and was found at the end of the parking lot near the road. Resident #57 was lying on the ground with his wheelchair behind him. He was not injured. 1 of 2 residents were reviewed for wandering behaviors (Resident #57). Immediate jeopardy began 3/17/22 when Resident #57 exited the facility unsupervised and sustained an unwitnessed fall. Immediate jeopardy was removed on 5/16/22 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal plan. The facility will remain out of compliance at lower scope and security of D (no actual harm with the potential for minimum harm that is not immediate jeopardy) to ensure the monitoring of systems put in place and to complete facility employee and agency staff in-services, orientation and training. Findings included: Resident #57 was readmitted to the facility on 2/03/19 with diagnoses that included psychosis, insomnia, bilateral below knee amputations, fall history, depression, dementia and bipolar	F 689	Regarding the alleged deficient practice of failure provide adequate supervision to prevent accidents as evidenced by: a. Failure to increase supervision of Resident #57 knowing he had a history of removing his wanderguard device and b. Failure to monitor the placement of Resident #57 wanderguard • Resident #57 was placed on one-to-one monitoring on 5/12/22 and will remain on one-to-one supervision until the Interdisciplinary team determines he is no longer at risk of removing his wanderguard or another plan is determined to be appropriate by the interdisciplinary team. Resident #57's careplan was updated by the DON to reflect current wandering and elopement risk and one-to-one supervision on 5/12/22. • Residents wearing wanderguards were determined to have the potential to remove wanderguards and exit the facility unsupervised. All residents with wanderguards were checked on 5/12/22 to verify all were in place and functional by the nurses. Careplans of all residents with wanderguards in use were reviewed by the DON on 5/13/22 to identify other residents at risk of removing or attempting to remove their wanderguard. No other residents were determined to be at risk at this time. • Education of all facility staff on	

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F 689	Continued From page 29 disorder. On 7/14/20 a care plan was initiated and last reviewed on 4/22/22 for Resident #57 revealed, in part, that Resident #57 had exit seeking behaviors and stated he was leaving to live in the community. Resident #57 had increased confusion and constantly removed his wanderguard by cutting the band with a butter knife. The goal was that Resident #57 would remain safe in the facility unless accompanied by staff or family. Interventions were to notify staff of elopement (leaving an area without permission or supervision), redirect and allow time to verbalize feelings, check wanderguard placement every shift (located on the back of his wheelchair), monitor his room for butter knives. Physician (MD) orders dated 09/27/21 included to check Resident #57's wanderguard for placement and location every shift. A progress note by the Doctor of Osteopathy (Osteopathy defined as the use of a whole person approach to help prevent illness and injury) note dated 3/4/22 included that Resident #57 was a poor historian due to cognitive and psychiatric impairment. Resident #57 had impaired insight and delusions, he was forgetful and stated "I gotta get out of here." Resident #57 was independent in the wheelchair. Resident #57 was followed by mental health for poor decision making capacity and persistent delusions with suspected vascular dementia. Nursing was to continue safety measures. A Psychiatry progress note dated 3/4/22 revealed, in part, Resident #57 had major neurocognitive disorder of unknown etiology no reported	F 689	wandering and elopement with a post-test was initiated by the DON on 5/12/22 with all facility staff working at that time. Any facility staff not present at the time will receive the education with post-test on their next scheduled work day. New staff will receive the education during orientation. The DON or designee will review new admissions for potential elopement risk and ensure appropriate interventions are added to the careplan. Residents with elopement potential will be listed by the DON or designee in the “Code Silver” binders at each nurses station with residents face sheet and picture. The binders are accessible to all facility staff. Starting 5/13/22 residents identified as having a change of condition to include elopement potential by the interdisciplinary team will be placed on one-to-one until appropriate interventions to decrease the potential of elopement are careplanned, implemented and the resident has been added to the “Code Silver” binders. • The Director of Nursing or Unit Managers will review all newly completed elopement assessments to ensure that any resident identified as at risk has appropriate interventions in place for 1 week, then 5 assessments per week for 4 weeks, then 10 per month until substantial compliance is achieved. Audits will be presented to the Quality Assurance team for further recommendations until consistent compliance is met.	

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disruptive behaviors or moods reported at that time.

An Elopement Evaluation form dated 3/09/22 at 7:18 AM included that Resident #57 had verbally expressed the desire to go home and packed his belongings and he stayed near the exit door with his belongings. Resident #57 exhibited patterned wandering which did not affect the safety or well-being of other or to himself. Staff was educated that Resident #57 was an elopement risk, to monitor his location frequently and monitor that Resident #57 always had a personal alarm in place. This evaluation was complete by Nurse #2.

On 5/10/22 at 2:35 PM a phone interview was conducted with Nurse #2. Nurse #2 explained she worked mainly weekends and she had completed the Elopement Evaluation form for Resident #57 on 3/13/22 because the electronic medical record (EMR) notified her that it was due that day. Nurse #2 revealed Resident #57 had a risk for elopement and had the risk for a few years. Resident #57 wore a wanderguard bracelet on his wrist or it was attached to his wheelchair at various times and that Resident #57 always seemed to locate his wanderguard and removed it no matter where it was located on his body or his wheelchair. Nurse #2 also revealed that Resident #57 had sometimes used a butter knife and cut the straps to get the alarm off which was the reason he was served only plastic utensils but Resident #57 still wandered into the dining room and seemed to locate a metal butter knife and cut the strap when no one was looking. Nurse #2 explained the wanderguard door alarm and personal wanderguard bracelet were checked at least once daily and recorded in the EMR. Nurse #2 explained that the nurse staff had a small

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battery-operated machine to test the resident alarms for function and the box flashed an indicator message when it was held near a resident with a wanderguard it flashed if the alarm was present and functioning or not. Nurse #2 revealed that Resident #57 had never eloped from the facility before or after the elopement on 3/17/22, but that he did wheel himself toward exit doors sounding the alarm and staff would direct him away from the door and coded the door alarm to go off and reset. Nurse #2 reported that Resident #57 would tell her he needed to leave to go home to get supplies to load onto his spaceship. Nurse #2 explained that if it was determined that a resident was missing that the nurse or other staff used the intercom and announced a Code Silver that alerted all facility staff to start to look for a particular resident and that the facility also maintained Code Silver books at each nurse station that included a resident photo, a copy of the resident's face sheet and any other material deemed necessary to locate and identify residents. Nurse #2 revealed she did not receive any new education or that the process had changed after Resident #57 eloped on 3/17/22.

A social worker (SW) progress note dated 3/9/22 at 1:21 PM included Resident #57 continued to have delusions and told the SW he had a great escape plan to get back to his businesses and his farmland was abandoned and he needed to attend to it. Resident #57 was redirected as needed.

A review of a quarterly Minimum Data Set (MDS) dated 3/10/22 revealed in part that Resident #57 had clear speech, was usually understood and sometimes understood. Resident #57 rejected

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care 1 to 3 days of the review period and required 1 staff assist with bed mobility, he did not require staff set up assist to transfers, locomotion. Resident #57 was steady with no assist to move from sit to stand and surface to surface transfers. He used a wheelchair and prosthetics for mobility. Resident #57 had one fall without injury and one fall without major injury during the review period. No active discharge plans were in place.

A review of multiple MDS assessments for Resident #57 dated from 10/03/20 through 3/10/22 revealed that Resident #57 had fluctuating cognition patterns.

A Nurse Practitioner (NP) note dated 03/16/22 included, in part, that Resident #57 was a poor historian due to cognitive and psychiatric impairment and received psychiatric and psychological services with minimal ability to provide his history. The NP recorded on examination Resident #57 had impaired insight, was delusional and forgetful.

A review of the medication administration record dated for3/17/22 revealed that Resident #57's wanderguard was checked on the day shift and the evening shift and functioned appropriately and was located directly under the wheelchair seat as high up on the cross bars as it would fit.

Nurse #3 was interviewed via phone on 5/11/22 at 3:31 PM. Nurse #3 revealed she worked from 7:00 PM on 3/17/22 until 7:00 AM on 3/18/22 and was the assigned to the rehab unit. Nurse #3 revealed she believed Resident #57 exited the facility about 8:30 PM because it was dark outside and she had just finished her medication pass when the pharmacy delivery driver from the

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pharmacy informed Nurse #3 that there might be a resident outside in a wheelchair going toward the street at the end of the side parking lot. Nurse #3 and the pharmacy delivery driver exited the facility to look for a resident and realized that a Code Silver (used for actual or potentially missing residents) had not been announced. Nurse #3 and the pharmacy delivery driver just ran out of the facility toward the road and observed Resident #57 lying in the dirt at the side of the road with his wheelchair right behind him. The traffic had stopped in both directions. Nurse #3 confirmed that neither Resident #57 nor his wheelchair were in the road. Resident #57 had both of his leg prosthetics on. Nurse #3 did not observe any injury to Resident #57 who also reported that he was not injured. Nurse #3 explained she and the pharmacy delivery driver tried to pick Resident #57 up off the side of the road but he was too heavy then a gentleman got out of his vehicle and came over and assisted them to place Resident #57 back into his wheelchair and it was then that Nurse #4 and Nursing Assistant (NA) #1 came running out of the facility and explained they were assigned to Resident #57 and were looking for him because they had not seen him for the last 15 to 20 minutes. Nurse #3 explained that Nurse #4 assessed and confirmed that Resident #57 had no injury and then Nurse #4 and the NA #1 wheeled Resident #57 back into the facility. Nurse #3 returned to her assigned unit. Nurse #3 explained that if a resident elopes from the facility a "Code Silver" was to be announced and all staff available were to begin searching the entire facility and proceed to search outside of the facility for the resident. Nurse #3 revealed that an unsupervised exit from the facility by a resident was to be reported to the Director of Nursing

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(DON) immediately and notification made to the MD and family of the resident even if the resident was listed as their own responsible party. Nurse #3 explained that complete vital signs, neurological checks and a full body assessment were to be completed, then an incident and/or accident report completed and a detailed progress note written and try to obtain written statements from any staff involved. Nurse #3 revealed that she had been assigned to Resident #57 a few times before 3/17/22 and she was aware he wore a wanderguard, but he had not exhibited any wandering or exit seeking behaviors when she was assigned to him. Nurse #3 reported that Resident #57 had shorts on when he eloped from the facility on 3/17/22 but she was not sure of the type of shirt he wore and that it was cool outside but not very cold or raining. Nurse #3 revealed that she completed and signed a statement that described what she observed on 3/17/22 directed by the nurse supervisor before she left the facility the morning of 3/18/22.

On 5/12/22 at 7:05 AM a follow up phone interview conducted with Nurse #3. Nurse #3 clarified that neither Resident #57 nor his wheelchair were in the road on 3/17/22 when he eloped and that he was observed approximately 15 feet from the end of the parking lot driveway on the facility side of the road. Nurse #3 confirmed that it was getting very dark outside and she believed the time was near 8:30 PM and the weather was mild.

On 5/10/22 at 3:35 PM a phone interview was conducted with NA #1. NA #1 revealed worked from 3:00 PM until 11:00PM on 3/17/22 and it was the first time she was assigned to Resident #57 so she did not know he wandered or had a

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wanderguard. NA #1 revealed that on 3/17/22 she was on her break sitting in her vehicle in the parking lot and when she exited her vehicle to return to the facility at about 8:00 PM she observed someone with their head down moving away from the 100 hall sunroom door in the back parking lot of the facility. NA #1 explained she was not sure if it was a resident or visitor or anyone else because she was in a different parking lot and it was dark outside and could just make out the top of a head. NA #1 went into the facility and Nurse #4 approached her and explained that Resident #57 was missing when the nurse was taking him his medicine. NA #1 revealed she informed Nurse #4 that she might have seen Resident #57 leaving the facility a few minutes ago when she was returning from her vehicle. NA #1 revealed both she and Nurse #4 proceeded to leave the facility at the 100 hall sunroom door where NA #1 had observed someone outside and when they got outside, they saw 2 staff and a man placing Resident #57 into his wheelchair. NA #1 revealed that Nurse #1 examined Resident #57 and asked him if he was injured and he told her he was fine. NA #1 revealed that she did not see any cuts or scratches on Resident #57. Then, NA #1 stated that she and Nurse #1 wheeled Resident #57 into the facility and to his room and placed him in his bed. Resident #57 told Nurse #4 and NA #1 that he was angry and would only leave the facility again. Resident #57 also reported to the nurse staff that he cut his alarm bracelet off so Nurse #4 went and got another wanderguard alarm and attached it under the chair cushion on his wheelchair. NA #1 revealed she had not been aware the Resident #57 cut the straps of the wanderguard off and that was likely why the alarm never sounded at the door. NA #1 revealed

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that she had been assigned to sit in the doorway of Resident #57's room after that and for the rest of the 3:00 PM to 11:00 PM shift. Resident #57 remained asleep in his bed reported NA #1 and she was able to recall that Resident #57 wore shorts and his prosthetic legs when he was outside.

Nurse #1 was interviewed on 5/09/22 at 4:26 PM and revealed she worked from 7:00 AM until 7:00 PM the on 3/18/22 and was assigned to Resident #57 and he always wore a wanderguard. Nurse #1 revealed the current wanderguard was under the cushion of his wheelchair and the wanderguard was checked daily or more frequent if needed because Resident #57 removed the attachment strap and removed the alarm if he was able to by cutting the strap with a butter knife. Nurse #1 obtained the wheelchair from the room of Resident #57 as he slept in his bed and she wheeled the chair to the exit door at the end of the 100 hall and was approximately 10 feet from the door when the alarm sounded. Nurse #1 explained that the alarm automatically locked the door and needed a code entered the keypad to the left side of the door to silence the alarm and unlock the door after the wheelchair was moved back approximately 10 to 12 feet from the door alarm.

A review of a nurse note dated 3/18/22 at 1:10 AM by Nurse #4 revealed that at approximately 8:40 PM on 3/17/22 Resident #57 was not in his room when she went to administer his bedtime medications. The nurse began looking for him and an NA told the nurse that she (the NA) thought she saw someone in the parking lot matching the description of Resident #57. Resident #57 was found outside just off the property near the road. He was assessed for

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injury and was not injured his skin was intact. Resident #57 reported that he just wanted to go home. Resident #57 was educated on the proper procedure to sign out of the facility correctly and about giving notice to set up transportation and escort him safely. Resident #57 stated understanding of the proper procedure. Resident #57 was his own responsible party.

Multiple attempts were made to contact Nurse #4 during the survey but were unsuccessful.

A review of a late entry nurse progress note completed by Nurse #4 on 3/18/22 at 7:52 AM included that the DON was notified at 8:51 PM on 3/17/22 that Resident #57 got out of the facility near the street.

An observation and interview of Resident #57 conducted on 5/09/22 at 4:02 PM revealed Resident #57 seated in his wheelchair in his room, wearing bilateral lower leg prosthesis. Resident #57 was awake and alert to himself his speech was clear but nonsensible. He reported that the date was Tuesday in March of 1944. Resident #57 revealed he did not live here very long and the name of the place was 104 in Concord. Resident #57 also revealed he remembered he fell outside but was not certain exactly when, but he went outside one of the doors and his wheelchair got caught on the edge of the door and he fell, but he did not get hurt. Resident #57 added he was going outside because the lady with the menus told him to come outside quickly and that was why he fell.

On 5/11/22 at 6:35 AM a weather search conducted on wunderground.com recorded the temperature during the late evening of 3/17/22 in

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Concord, NC as partly cloudy and 61 degrees Fahrenheit.

An interview conducted with the registered dietician (RD) on 5/11/22 at 11:27 AM revealed that Resident #57 received plastic utensils with his meal trays because he sometimes used the metal butter knives to cut the strap of his wanderguard alarm. The RD was not able to recall when the plastic silverware use had been initiated but he was care planned at one time for the use of plastic silverware but the RD had no idea what happened to that care plan because it remained current. The RD explained that after meals the meal carts were brought to the dining room to be taken into the kitchen to be washed and sometimes Resident #57 had been observed coming into the dining room and attempting to remove silver butter knives from the dirty meal trays. The RD revealed when she observed this behavior, she stopped Resident #57 and retrieved the knife or knives from him and redirected him to exit the dining room.

On 5/11/22 at 1:00 PM an interview and observation of the wanderguard door alarms was conducted with the Maintenance Director. The Maintenance Director revealed that the facility had 18 doors that had alarms that were activated by wanderguard bracelets. The Maintenance Director explained that he checked all door alarms every morning and he used a test stick to activate each alarm that automatically sounded the alarm and locked the doors. The Maintenance Director explained that he was not at work when Resident #57 eloped from the facility, but that nurse Unit Manager (UM #1) had been assigned to test the door alarms when he was not present. The 18 doors of the facility were observed as they

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were tested and no concerns were identified. The Maintenance Director then obtained the wheelchair that belonged to Resident #57 and pushed it close to the door at the end of the 100 hall and it alarmed and the door locked. The Maintenance Director explained that when the door alarmed it automatically locked as the alarm sounded and could only be disarmed and unlocked when a staff member entered the correct code into the keypad located on the wall to left of each alarmed door. The Maintenance Director stated that he had been informed that Resident #57 exited the facility at the door of the sunroom near room 120 and that from the sunroom to the roadway measured 65 feet to 70 feet. The speed limit sign on the road next to the facility revealed the speed limit was 35 miles per hour. The Maintenance Director reviewed his daily logbook that contained daily door alarm checks from 1/2020 until 5/11/21 and the log dated 3/17/22 revealed that UM #1 signed that all the door alarms functioned as required.

An interview conducted with the NP on 5/11/22 at 2:40 PM revealed that she was aware that Resident #57 had an elopement on 3/17/22, but never prior to that date. The NP explained that Resident #57 had become more delusional over the past few years with more verbalizations of wanting to go home. The NP revealed that she was made aware that Resident #57 eloped on 3/17/22 because she received notification from the on-call service and then had received more details when she came to the facility on 3/23/22 at which time she examined Resident #57 , found no injury and Resident #57 acted no different and spent most of the day seated in his wheelchair in the doorway of his room. The NP revealed that in her medical opinion Resident #57 was not able to

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make medical care decisions for himself.

An interview conducted on 5/11/22 at 4:00 PM with UM #1. UM #1 revealed that she usually worked weekdays until about 5:00 PM and she was responsible to check the 18 door alarms and locks daily when the Maintenance Director was out at the facility and she did check the door alarms on 3/17/22 and all doors functioned appropriately. UM #1 revealed that on 3/17/22 she had not observed any concerns that Resident #57 experienced any changes in his status and she was leaving the facility for the day at about 6:30 PM. She was not certain of the exact time, but she had just went out to her vehicle in the front parking lot when she received a phone call from an unknown visitor at the facility who informed her that a resident in a room on the 100 hall about half way had been observed seated in his bed and he had is wheelchair turned upside down and was "fiddling" with something. UM #1 then called the facility to speak to the nurse assigned to that 100 hall but the nurse was not available and UM #1 told the NA that answered the phone to tell the nurse what was reported by the visitor and that someone needed to check on Resident #57 because UM #1 believed it was Resident #57. UM #1 revealed she was about to leave the parking lot driveway when she received a phone call from Nurse #3 and was informed that Resident #57 had been found outside lying on the side of the road with his wheelchair behind him and that at one point traffic stopped on both sides of the road. Nurse #3 explained that she and another staff member went out of the facility together and that a man had gotten out of his car to assist lifting Resident #57 back into his wheelchair. Nurse #3 revealed that Resident #57 had no visible injury and stated he was not injured

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and 2 other staff came out of the facility (1 was a nurse) and the nurse assessed Resident #57 and then the nurse and NA rolled Resident #57 back into the facility. UM #1 revealed that she returned to the facility and spoke to Nurse #4 assigned to Resident #57 and Nurse #4 explained she had been taking bedtime medications to Resident #57 in his room and he was not there and the NAs helped to look for him inside the facility and then NA #1 reported to Nurse #3 that she may have observed Resident #57 outside and both Nurse #3 and NA #1 went outside and saw 2 other staff and a man lifting Resident #57 back into his wheelchair and he had no injuries and she and NA #1 wheeled him back to his room and assisted him to bed. UM #1 revealed she instructed Nurse #3 to document what happened and to notify the DON, MD and family as well. UM #1 explained that she then went to Resident #57's room and observed him in bed with his prosthetics removed. Resident #57 told UM #1 that he was angry and that he would only leave again. UM #1 revealed when she asked Resident #57 where the wanderguard bracelet that had been attached to his wheelchair earlier that day was and Resident #57 pointed to the top drawer under his closet. When she opened it, she found 2 wanderguard battery pieces and 1 rubbery bracelet used to attach the wanderguard to a resident or wheelchair along with 2 silver butter knives in the drawer which she removed from the room. UM #1 reported that the NA present in Resident #57's room at that time explained that she was going to stay with him for the rest of her shift at 11:00 PM and replaced the wanderguard. UM #1 revealed that she then left the facility after Nurse #3 confirmed that the DON had been notified. UM #1 revealed that based on the information she received, Resident #57 was

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outside for no more than 15 minutes to 20 minutes and he was not injured. UM #1 revealed that Resident #57 had a history of removing his wanderguards from any place the staff attached them and in the recent past he removed wanderguards attached to his wrist, from the bars on the bottom of his wheelchair and even tucked under the chair cushion on his wheelchair. UM #1 explained that he only received plastic silverware because he used the knives to cut the bracelets, but he somehow managed to get the metal knives and used them. UM #1 obtained the personal alarm test box and was observed standing at the back of Resident #57's wheelchair and the code flashed that the wanderguard alarm was present and functioning. UM #1 went on to explain that if a resident exited or eloped from the facility unsupervised then the staff was to call a Code Silver to alert all present staff that a resident was missing and that all staff was expected to search inside and outside the facility. UM #1 added that the nurse was to notify the DON, MD and family of the episode and to obtain full vital signs and neurological checks as part of the resident assessment required and the to write a detailed nurses note and complete an incident and/ or accident report. UM #1 revealed that she had not viewed an incident and/ or accident report or investigation completed for Resident #57 dated 3/17/22.UM #1 revealed that Resident #57 was confused most of the time but more confused over the past few months. UM #1 added that the facility did not implement any new interventions to the care plan of Resident #57 related to the elopement or fall on 3/17/22.

A form titled wanderguard Residents dated from 3/01/22 through 3/31/22 was reviewed and the form listed each resident's name, room number

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and verified the placement and function of each resident and their wanderguard daily and was signed by the person responsible to check residents and their wanderguards. The form included Resident #57 had a functional wanderguard in place daily.

On 5/12/22 at 10:13 AM an interview was conducted with the facility MD. The MD explained that Resident #57 had experienced a decline in his cognition over the last few years and Resident #57 had experienced more delusions and even hallucinations over the past year or more and was not capable making his own care decisions. Resident #57's cognition and behaviors change daily per the MD.

On 5/10/22 at 5:28 PM a brief interview conducted with the DON revealed that she completed an investigation for the elopement and fall of Resident #57 beginning 3/18/22 through about 3/23/22. The DON confirmed that on 3/17/22 after Resident #57 was safely returned to the facility no other safety interventions were put in place to prevent future elopements because at the time of the unsupervised exit from the facility, Resident #57 was his own responsible party and based on the most recent MDS date 3/10/22 Resident #57 had no cognitive impairment. The DON confirmed that Resident #57 had fluctuations in cognitive status but as his own responsible party he could not be prevented from leaving the facility if that was the decision he made. The DON revealed that Resident #57 was not a prisoner and could not be made to stay at the facility if he did not want to. The DON did not reply when asked what the purpose of the wanderguard was in that case.

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On 5/12/22 at 3:56 PM the DON was interviewed and revealed that when a resident eloped, she expected the licensed nurse to contact her and the nurse did call her on 3/17/22 about Resident #57 being found lying next to the street between 8:30 PM and 9:00 PM. The DON revealed that she expected all residents always be accounted for. The DON also revealed that Resident #57 had verbalized exit seeking behaviors in the past and that he still does. The nurses revealed the DON were to also notify the MD and family of any incident and/ or accident and were to complete all documentation needed for the exact episode. The DON believed that the nurse staff and facility followed up as required and expected on 3/17/22 related to Resident #57. The DON revealed that Resident #57 was not outside for longer than 15 to 20 minutes.

Administrator was notified of immediate jeopardy on 5/12/22 at 4:39 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered or are likely to suffer a serious adverse outcome as a result of noncompliance.

Resident #57 left the facility unsupervised after cutting off his wanderguard on 3/17/22. Residents wearing wanderguards were determined to have the potential to remove wanderguards and exit the facility unsupervised. Resident #57 was placed on one-to-one monitoring on 5/12/22 and will remain on one -to- one supervision until the Interdisciplinary team determines he is no longer at risk of removing his wanderguard or another plan is determined to be appropriate by the

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interdisciplinary team. Resident #57's care plan was updated by the DON to reflect current wandering and elopement risk and one-to -one supervision on 5/12/22.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring.

The Elopement and Wandering residents policy was reviewed on 5/12/22 by the DON and Administrator; no changes were made.

All exits and wanderguard alarms were checked and functional on 3/18/22 by maintenance. They continue to be functional as evidenced by check completed on 5/12/22 by maintenance. Functional checks will continue weekly by maintenance. Education of all facility staff on wandering and elopement with a post-test was initiated by the DON on 5/12/22 with all facility staff working at that time. Any facility staff not present at that time will receive the education with post-test on their next scheduled workday. The DON or designee will use the staff roster to verify that all staff have received the education with post-test.

The DON or designee will review new admissions for potential elopement risk and ensure appropriate interventions are added to the care plan, the Kardex reflects the care plan and is accessible to direct care staff. Residents with elopement potential will be listed y the DON or designee in the "Code Silver" binders at each nurses station with each resident's face sheet and picture. The binders are accessible to all facility staff.

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Starting 5/13/22 residents identified as having a change in condition to include elopement potential by the interdisciplinary team will be placed on one-to-one until appropriate interventions to decrease the potential of elopement are care planned, implemented and the resident has been added to the "Code Silver" binders.
The wandering and elopement education with post-test was added to the orientation materials on 5/12/22 by the DON.

Date alleged Immediate Jeopardy removal: 5/16/22.

The facility's credible allegation of compliance was validated through an on-site review process which included record review, observations, interviews with staff and observations. Date of IJ removal was validated as of 5/16/22.

The validation of the credible allegation conducted on 5/16/22 included that 97 staff had completed in-service education and a post test of the policy and procedure related to elopement and wandering residents. Random staff were interviewed and were able to explain the facility policy related to elopement and the use of the Code Silver binders located at each nurse station. Resident #57's care plan was updated to include one to one supervision at all times and the placement and function of his wanderguard was recorded every shift by the nurses. Resident #57 was observed with an NA providing direct one to one supervision at all times. Audits completed by the DON included an audit of each resident with a wanderguard that confirmed the placement and function of each wanderguard, a wanderguard assessment and a copy of each resident care

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F 689	Continued From page 47 plan updated to reflect use of the wanderguard.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure 1 of 3 medications carts, Medication Cart #5, had insulin labeled with the date when opened and expired medications were discarded; and failed to dispose of expired medications in 1 of 2 medication rooms, 200 Hall Medication Room.	F 761	Regarding the alleged deficient practice of failure to store all drugs labeled in accordance with currently accepted professional principles, including expiration date when applicable, as evidenced by: a) Failure to dispose of expired insulin	6/16/22

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F 761	Continued From page 48 Findings: 1. An observation of the #5 Medication Cart on 5/12/2022 at 3:04 pm revealed there was a Glargine Insulin pen that was opened 4/6/2022 and should be discarded in 28 days according to the label on the insulin pen. There was also a Novolog Insulin pen that was not dated with 100 units used from the pen. During an interview with Nurse #5 she stated she was not sure who had opened the Glargine Insulin pen and the Novolog Insulin pen. Nurse #5 also stated when an insulin pen is opened it should be dated on the label with the date it was opened. Nurse #5 stated the medication carts should be checked for expired medications daily. 2. The 200 Hall Medication Room was observed on 5/12/2022 at 3:59 pm and there were three bottles of over the counter supplements that were expired. There were two bottles of B Complex Dietary Supplement which expired 2/2022 and one bottle of Vitamin D3 which expired on 2/2022. An interview was conducted with Nurse #6 on 5/13/2022 at 10:04 am and she stated she came to work at the facility in 3/2022 and is not sure who should check for expired medications in the medication rooms. On 5/12/2022 at 4:15 pm an interview was conducted with the Director of Nursing (DON) and she stated the nurses should check the medication carts each shift and the Unit Managers should check the Medication Rooms each morning for any expired medications or unlabeled medications.	F 761	pen or to label an insulin pen on medication cart 5, b) Failure to dispose of expired medication in 200 hall medication room. On 05/12/2022, insulin pens on med cart 5 were discarded and expired medications in med room were discarded. All other medication carts and medication rooms were audited on 05/13/2022 with no additional findings. Beginning on 06/2/2022, the Director of Nursing (DON) provided in-service education to the unit coordinators, and nursing staff regarding requirements for labeling, storing, and discarding of medication, with education to continue upon return to work for all licensed nurses. Beginning on 06/16/2022, licensed nurses will audit the med carts at least three times weekly for unlabeled, expired or opened and/or opened and undated medications. The DON and/or Unit Coordinators will audit medication rooms, medication carts and medication cart audits weekly for 4 weeks, then twice a month for 2 months to assure and validate substantial compliance. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 761	Continued From page 49 During an interview with the Administrator on 5/13/2022 at 5:30 pm he stated the nursing staff should be checking the medication carts and medication rooms and ensuring there are not expired medications used.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to discard stored food products for use on or before the expiration date. The facility also failed to keep cold food items for the lunch meal at or below 41 degrees Fahrenheit. These practices had the potential to affect the food served to residents.	F 812	Regarding the alleged deficient practice of failure to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidenced by: c) Failure to discard stored food prior to or on the expiration date d) Failure to keep cold food items at or	6/13/22

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F 812	Continued From page 50 The findings included: 1. An observation with the Assistant Dietary Manager (ADM) of the cooler refrigerator occurred on 5/9/22 at 10:13 AM with the following concern identified: a. One plastic storage bag of about 20 hot dogs expired 5/7/22; b. Diet jelly expired 4/26/22 (200 count box; 108 remained). c. Seedless raisins expired 11/20/21 (5 of 10 pounds (lbs). d. Chocolate chip cookies expired 3/12/22 (2 packages) An interview with the ADM on 5/9/22 at 10:13 AM revealed she began working at the facility five years ago and as an ADM for two years. She stated that she alone was responsible for checking expired dates on food and discarding them. She further stated that she was responsible for signing the refrigerator and freezer log indicating the refrigerated and dry storage items were checked. She threw out the expired foods. 2. An observation of temperatures for dinner items on the steam table began on 5/10/22 at 4:19 PM with Registered Dietitian (RD) who obtained the food temperatures via a digital thermometer. The following concerns were identified: a. Chicken salad sandwiches (120 count) had a holding temperature of 49 degrees Fahrenheit. b. Pureed chicken salad had a holding temperature of 65 degrees Fahrenheit. c. Pureed pasta salad had a holding temperature of 66 degrees Fahrenheit.	F 812	below 41 degrees Fahrenheit On 05/09/2022, the expired foods were discarded. On 05/10/2022, the prepared cold food items above 41 degrees Fahrenheit were discarded and re-prepared for serving. Beginning on 05/11/2022, the facility administrator (NHA) provided inservice education to the Dietary Manager, Registered Dietitian and dietary staff regarding requirements discarding stored food on or before expiration dates, as well as storage of prepared, cold foods for serving, with education completed on 06/10/2022. Registered Dietitian or NHA will audit stored foods for expiration dates five times per week for four weeks, then two times per week for two months. Registered Dietitian (RD) or NHA will audit cold food items for appropriate temperatures five times per week for four weeks, then two times per week for two months. RD or NHA will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. RD or NHA will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 812	Continued From page 51	F 812		

An observation review of the in-service sheet dated 4/1/22 revealed dietary staff received an in-service on food quality, open containers, food temperatures, and food safety.

An interview with the RD on 5/10/22 at 4:19 PM revealed she was aware cold foods were to maintain a holding temperature of at or below 41 degrees Fahrenheit while on the steam table. She further revealed she provided on-going in-services to dietary staff regarding food safety. The RD was aware that the ice machine from 100 hall became disabled and retrieved ice from the kitchen's ice machine, which caused an ice shortage in the kitchen during dinner preparation. The RD directed dietary staff to discard the chicken salad sandwiches, pureed chicken salad, and pureed pasta salad. She also directed and assisted with preparing fresh chicken salad sandwiches, pureed chicken salad and pureed pasta that was to be served for dinner.

An interview with the ADM on 5/10/22 at 4:55 pm indicated she provided ice from the kitchen to 100 hall residents due to a broken ice machine on 100 hall that day. Therefore, there was not enough ice to keep the holding temperatures of the chicken salad sandwiches, pureed chicken salad and pureed pasta salad at or below 41 degrees Fahrenheit. The ADM participated in discarding the below temperature dinner items and retrieved fresh chicken salad, pureed chicken salad and pureed pasta salad from refrigerator to be served for dinner.

An interview with the Maintenance Director on 5/11/22 at 1:02 PM indicated he called in a service request for the ice machine on 100 hall,

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F 812	Continued From page 52 when it became disabled on 5/10/22.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review the facility failed to provide effective oversite to ensure 2 of 5 sampled residents (Resident #10 and Resident #82) had briefs available and the briefs were the correct size for residents sampled for accommodation of needs . Findings included: This tag is referenced to: F558 - Based on resident and staff interviews and record review the facility failed to have briefs available for a resident (Resident #10) and failed to provide the correct size of brief for a resident (Resident #82) for 2 of 5 sampled residents reviewed for accommodation of needs.	F 835	Regarding the alleged deficient practice of failure administer a facility in a manner that enables it to use its resources effectively as evidenced by: Failure to provide effective oversite to ensure 2 residents #10 and #82 had briefs available and the briefs were the right size Appropriately sized briefs were acquired for residents #10 and #82. All residents wearing briefs have the potential to be affected. An adequate supply of briefs of all sizes was obtained. The administrator was inserviced regarding providing oversite to ensure the facility has an adequate supply of briefs and sizes consistently available by the Chief Operating Officer on 6.1.22. The Administrator worked with the supply clerk to increase the supply of all brief sizes ordered weekly to meet facility needs. The administrator will oversee the orders and available stock to maintain an adequate supply of all sizes of briefs. The administrator will audit brief stock to ensure an adequate supply is maintained weekly for 1 month, then monthly for 3	6/1/22

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F 835	Continued From page 53	F 835	months or until substantial compliance is achieved or the quality assurance team recommends otherwise.	