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	345393	A. BUILDING _____ B. WING _____	C 06/10/2022

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PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

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E 000	Initial Comments An unnanounced Recertification and complaint survey was conducted on 6/6/2022 through 6/10/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RXXJ11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey and complaint investigation were conducted onsite 06/06/2022 to 06/10/22. A total of 17 allegations were investigated and 9 were substantiated. Intakes NC00187287, NC00186596, NC00185444, NC00182593, NC00182619, and NC00189702. Event ID# RXXJ11. On 7/5/22 the scope and severity of F 550 and F 725 were changed to H and the scope and severity of F 644 was lowered to D. The Administrator was notified by phone. The 2567 was amended and the survey was reposted.	F 000		
F 550 SS=H	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		7/4/22

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

Electronically Signed | 07/04/2022

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to maintain residents' dignity when there was a delay in answering their call light when toileting/incontinence care was needed, not providing showers/bathing assistance as scheduled and not providing assistance out of bed when requested resulting in residents feeling "dirty, mad, isolated and forgotten about." This affected 3 of 14 sampled residents (Residents #46, #84 and #87) reviewed for activities of daily living and dignity.	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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F 550	Continued From page 2 Findings included: 1. Resident #46 was admitted to the facility on 03/03/22 with diagnoses that included chronic atrial fibrillation (abnormal heartbeat), respiratory failure, chronic pain, and macular degeneration (eye disease that causes vision loss). The quarterly Minimum Data Set (MDS) dated 04/14/22 assessed Resident #46 with intact cognition. Resident #46 required physical assistance of one staff member, limited to transfer only, for bathing and displayed no rejection of care during the MDS assessment period. During an interview on 06/06/22 at 11:50 AM, Resident #46 was unaware of how many showers she was scheduled to receive each week and reported only receiving one shower since her admission to the facility. Resident #46 did not recall receiving any bed baths. Resident #46 stated due to her risk of falls, she needed staff assistance and when she didn't receive her showers, she stated "sometimes it's like I can feel the dirt on my face and I just feel dirty." During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #46's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would	F 550	F550 Resident Rights/Exercise of Rights Corrective Action for Affected Residents: For resident # 46, a corrective action was obtained on 6/9/2022. Nurse Aide (NA#3) provided bed bath to resident #46. NA was verbally re-educated immediately by the Director of Nursing, (DON) on the resident's right to dignity, respect and the right to make choices. For resident # 84, a corrective action was obtained on 6/9/2022. NA#2 provided bed bath to resident #184. NA was verbally re-educated immediately by the Director of Nursing, on the resident's right to dignity, respect and the right to make choices. For resident # 87, a corrective action was obtained on 6/9/2022. NA#4 provided bed bath and assistance with getting dressed and up to wheelchair to resident #87. NA was verbally re-educated immediately by the Director of Nursing (DON), on the resident's right to dignity, respect and the right to make choices. On 6/9/2022, Nurse Managers monitored halls to ensure call light being answered and incontinent care being provided as indicated. Corrective Action for Potentially Affected Residents: All residents who need assistance with	

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not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall.

During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #46's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #46's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON explained they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The Administrator and DON

activities of daily living have the potential to be affected by this alleged deficient practice. On 6/27/2022, the Director of Nursing and Administrator performed audits to ensure call lights being answered and care being provided per plan of care. Any resident identified with toileting/ incontinent needs bathing/shower assistance or assistance getting out of bed were promptly toileted or care provided by the assigned NA.

Systemic Changes:

On 6/27/2022, the Director of Nursing began in-servicing all current full time, part time and as needed (PRN) Nurses and NA's. This in-service included the following topics:
- Resident Rights
- Residents Rights and Providing Showers
- ADL care

The Director of Nursing will ensure that any Nurse or NA who has not received this training by 7/4/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and NA's who give residents care in the facility. Any nursing staff who does not receive scheduled

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F 550	Continued From page 4 both stated they would never want any resident to feel "dirty" due to not receiving a shower and were unaware Resident #46 voiced feeling that way. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed. 2. Resident #84 was admitted to the facility on 10/30/21 with multiple diagnoses that included wedge compression fracture of the vertebra, epilepsy (seizure disorder), and hypoxemia (low level of oxygen in the blood). The quarterly Minimum Data Set (MDS) dated 05/09/22 assessed Resident #84 with intact cognition. He required extensive assistance of one staff member with part of the bathing activity, total staff assistance with toileting and displayed no rejection of care during the MDS assessment period. During interviews on 06/06/22 at 11:02 AM and 06/09/22 at 10:30 AM, Resident #84 reported he had not had a complete bed bath or shower in "months." Resident #84 stated staff would clean him up after a bowel movement but "not what he would consider a good wiping down." Resident #84 further stated he was unable to get up to the bathroom independently and relied on staff to assist him with incontinence care but often had to lie in a soiled brief waiting on staff to respond to his call light. Resident #84 explained when waiting on staff assistance, he would tell himself staff were busy but then when he noticed them walking back and forth past his door without stopping to help him, it just made him "mad." Review of the facility call light response report	F 550	in-service training will not be allowed to work until training has been completed. Quality Assurance: Beginning 7/6/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance (QA) Tool for Monitoring Residents Rights. The monitoring will include interviewing or observing a sample of 5 residents for toileting, incontinent care needs, getting out of bed preference and bathing. This will be completed 3 x weekly x 2 weeks then weekly 2 weeks then monthly times 2 months or until resolved to ensure their needs are met. Quality Of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, Minimum Data Set (MDS) Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 7/4/2022	

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provided by the Administrator on 06/09/22 for Resident #84's room revealed the following:
On 06/03/22, the bedroom call light was engaged a total of 7 times throughout the day. The average response time was 16 minutes and the max response time was one hour and eleven minutes.
On 06/04/22, the bedroom call light was engaged a total of 3 times throughout the day. The average response time was 13 minutes and the max response time was 22 minutes.
On 06/05/22, the bedroom call light was engaged a total of 5 times throughout the day. The average response time was 16 minutes and the max response time was 45 minutes.
On 06/06/22, the bedroom call light was engaged a total of 7 times. The average response time was 12 minutes and the max response time was 39 minutes.
On 06/07/22, the bedroom call light was engaged a total of 7 times. The average response time was 12 minutes and the max response time was 35 minutes.
On 06/08/22, the bedroom call light was engaged a total of 7 times. The average response time was 12 minutes and the max response time was 32 minutes.

During an interview on 06/09/22 at 12:01 PM, the Administrator explained the call light response report did not distinguish the specific resident, only the room number where the call light was engaged and if it was engaged in the residents' room or bathroom. The Administrator stated all facility staff, not just the nursing staff, were instructed to assist with answering call lights and if the requested assistance was something the staff member was unable to provide, such as toileting or transfers, they were instructed to leave

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the call light on and notify the assigned NA.

During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #84's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall.

During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #84's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #84's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms,

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and private areas.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON explained they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed. In addition, both the Administrator and DON stated they would never want a resident to become "mad" while waiting for staff assistance and it was never acceptable for a resident to wait an hour and eleven minutes for staff to respond to their call light.

3. Resident #87 was admitted to the facility on 10/24/12 with multiple diagnoses that included hemiplegia and hemiparesis (loss of strength or paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

The quarterly Minimum Data Set (MDS) dated 05/11/22 assessed Resident #87 with mild impairment in cognition. She required extensive assistance of one staff member with part of the bathing activity, total assistance of two staff members for transfers and displayed no rejection of care during the MDS assessment period.

During an interview on 06/06/22 at 10:45 AM,

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Resident #87 stated she was supposed to receive two showers per week but did not get them regularly. Resident #87 further stated whenever she asked staff for a shower, they would tell her they were short-staffed. Resident #87 also voiced she engaged her call light this morning at 7:00 AM to request staff assistance with getting up out of bed and into her wheelchair. She could not recall the exact time her call light was answered but indicated the staff member turned off the call light, stated they were busy and would be back to assist her out of bed before lunch. Resident #87 voiced she preferred to be up out of bed right after breakfast but usually did not get assistance until mid-morning or just before lunch.

A follow-up interview and observation was conducted with Resident #87 on 06/08/22 at 10:25 AM. Resident #87 was lying in bed and stated she had engaged her call light to request assistance but staff had turned it off. Resident #87 voiced she did not like lying in bed until noon and wanted to up in her wheelchair so she could go out into the facility. Resident #87 stated she felt "isolated and forgotten about" when left in the bed.

Review of the facility call light response report provided by the Administrator on 06/09/22 for Resident #87's room revealed the following:
On 06/03/22, the bedroom call light was engaged a total of 5 times throughout the day. The average response time was 12 minutes and the max response time was 45 minutes.
On 06/04/22, the bedroom call light was engaged a total of 5 times throughout the day. The average response time was 17 minutes and the max response time was 36 minutes.
On 06/05/22, the bedroom call light was engaged

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a total of 5 times throughout the day. The average response time was 24 minutes and the max response time was 48 minutes.
On 06/06/22, the bedroom call light was engaged a total of 10 times. The average response time was 16 minutes and the max response time was 28 minutes.
On 06/07/22, the bedroom call light was engaged a total of 5 times. The average response time was 14 minutes and the max response time was 35 minutes.
On 06/08/22, the bedroom call light was engaged a total of 4 times. The average response time was 4 minutes and the max response time was 41 minutes.

During an interview on 06/09/22 at 12:01 PM, the Administrator explained the call light response report did not distinguish the specific resident, only the room number where the call light was engaged and if it was engaged in the residents' room or bathroom. The Administrator stated all facility staff, not just the nursing staff, were instructed to assist with answering call lights and if the requested assistance was something the staff member was unable to provide, such as toileting or transfers, they were instructed to leave the call light on and notify the assigned NA.

During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #87's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as

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meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall. NA #2 confirmed Resident #87 preferred to be up out of bed after breakfast and she tried her best to accommodate her preference but when she was the only NA assigned to the hall, it might take her a little longer to provide assistance.

During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #87's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #87's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.

During an interview on 06/09/22 at 4:41 PM, NA #6 revealed she was routinely assigned to Resident #87's hall with anywhere from 20 to 27 residents on her assignment. NA #6 explained when short-staffed and assigned 20 or more

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F 550	Continued From page 11 residents, she wasn't able to provide residents with their scheduled showers and focused on keeping the residents safe, dry and fed. NA #6 confirmed Resident #87 preferred to be up out of bed right after breakfast and would yell out for staff if they were not there to assist her right when she expected. NA #6 explained although they tried to answer call lights as soon as possible, when working short-staffed call light response time increased. A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON explained they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed. In addition, both the Administrator and DON stated they would never want any resident to feel "isolated or forgotten about" and were not aware Resident #87 felt that way. The DON explained it was likely the NA was waiting on another staff member to assist them with transferring Resident #87; however, she should not have to wait 45 minutes for staff to respond to her call light and provide assistance.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		7/4/22

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	345393	A. BUILDING _____ B. WING _____	C 06/10/2022

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F 554	Continued From page 12 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 resident reviewed for self-administration of medications (Resident # 104). Findings included: Resident #104 was admitted to the facility 05/14/19 with diagnoses including aphasia (loss of ability to understand or express speech) and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 05/27/22 revealed Resident #104 was moderately cognitively impaired and received an antidepressant 7 out of 7 days during the look back period. An observation of Resident #104's overbed table on 06/06/22 at 12:38 AM revealed a clear plastic cup containing 1 red capsule, 1 white round tablet, and 1 white oblong table sitting on the table. Resident #104 was observed at the same date and time to be in bed with her eyes closed. An interview with Nurse #5 on 06/06/22 at 12:42 PM revealed she set the cup of medications on Resident #104's overbed table earlier the morning of 06/06/22. She explained when she brought the medications in the room Resident #104 was asleep and she woke the resident up to take her medication. Nurse #5 stated there were 4 pills in the medication cup and Resident #104 took 1 of	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 554- Resident Self- Admin Meds- Clinically Approp. Corrective action for resident(s) affected by the alleged deficient practice: For resident #104 the medication was administered on 6/6/2022 by the assigned nurse. Nurse #5 verbally re- educated on the need to administer all medications and observe that they have been taken by the resident. Physician notified and no new orders. On 6/10/2022, Assessment by the nursing team indicated that resident was not candidate for self-administration of medications. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 6/28/2022, the Director of Nurses and	

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F 554	Continued From page 13 the pills which she thought was tramadol (a narcotic pain mediation), but she wasn't sure. She stated she was called to another room and did not observe Resident #104 finish taking her medications. Nurse #5 stated the red capsule in the cup was docusate sodium (a laxative) 100 milligrams (mg), the round white tablet was escitalopram oxalate (an antidepressant) 5mg, and the white oblong tablet was either memantine (a cognition-enhancement medication) 5mg or tramadol (a narcotic pain medication) 50mg. She stated she usually stayed with residents when administering medications to make sure they took all their medication without difficulty. Nurse #5 confirmed Resident #104 did not have an order to self-administer medications. An interview with the Director of Nursing (DON) on 06/06/22 at 01:22 PM revealed she expected the administering nurse would stay with the resident until all medications were taken and not leave medications unattended at the bedside. She stated she would try to find out if the white oblong tablet was tramadol or memantine. A follow-up interview with the DON on 06/07/22 at 03:20 PM revealed that after talking with Nurse #5, it was determined Resident #104 took the tramadol when Nurse #5 was in the room the morning of 06/06/22 and the white oblong pill left in the medication cup was memantine. An interview with the Administrator on 06/09/22 at 05:28 PM revealed nurses should stay with residents throughout medication administration and the only time medications should be left at the bedside was if there was a care plan for the resident to self-administer medications.	F 554	Unit Managers audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no residents identified who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/27/2022, the Director of Nurses began education of all Full Time, Part Time, as needed (PRN) and agency nurses on facility policy related to medication safety that included resident assessment for self -administration of medication process and safely securing and storing medications. Education will be completed by 7/4/2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and Nurse aide (NA)'s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/4/2022. The monitoring procedure to ensure that	

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F 554	Continued From page 14	F 554	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: On 7/6/2022, Quality assurance monitoring will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits of 5 resident rooms will be completed on various days of the week and shifts to assure compliance with the medication storage policy. Audits will be done weekly for 4 weeks, then monthly for 2 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Unit Manager, Social Worker, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 7/4/2022	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		7/4/22

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F 558	Continued From page 15 §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 observations, record review, resident, and staff interviews, the facility failed to place the call light within reach for 1 or 1 resident reviewed for accommodation of needs (Resident #18). The findings included: Resident #18 was admitted to the facility on 06/25/16 with diagnoses including dementia, anxiety disorder, and depression. The most recent quarterly Minimum Data Set (MDS) dated 03/18/22 assessed Resident #18 as having clear speech, adequate vision but rarely and/or never was understood with the ability to sometimes understand others. The MDS indicated Resident #18 did not participate in the mental status interview and her cognition was considered severely impaired by a staff assessment. Resident #18 needed extensive assistance with bed mobility, transfers, toilet use, and was always incontinent of bladder and bowel. The care plan last revised on 04/20/22 identified Resident #18 as having a self-care performance deficit related to weakness. Interventions included encourage to use the call light and call for assistance. An observation and interview were conducted on	F 558	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F558- Reasonable Accommodations Corrective action for resident(s) affected by the alleged deficient practice: Resident #18- On 6/10/2022, Director of Nursing assessed resident to ensure call light was in reach. Call light within reach and resident voiced no concerns. Director of Nursing verbally reeducated Nurse Aide #1 related to placement of call light within resident reach. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 558	Continued From page 16 06/08/22 at 10:52 AM with Resident #18. Resident #18 was in bed with the call light cord placed between the mattress and bed rail with the red engage button dangling towards the floor. Resident #18 stated she would turn the call light on by mashing the red button and would use it to ask for something to drink or if she needed to be changed. When asked if she knew where the call light was, Resident #18 was unable to locate it. Observations made on 06/10/22 at 11:18 AM and 1:09 PM revealed Resident #18 lying in bed with the head of the bed raised. The call light cord was draped over the mattress at the head of the bed with the red engaged button dangling behind the bed towards the floor. When asked if she knew where the call light was Resident #18 was unable to locate it. An observation and interview were conducted on 06/10/22 at 1:09 PM with the Director of Nursing (DON) and Resident #18. The DON observed Resident #18's call light cord draped over the head of the bed with the red engage button dangling towards the floor. The DON asked Resident #18 if she would use her call light, Resident #18's response was, "if she needed to be changed" and begun to search for the call light but was unable to locate it. The DON placed the call light within reach and Resident #18 demonstrated she was able to engage the light. The DON stated the call light should be within reach for use, but she was unsure if Resident #18 would use it and stated Resident #18 was passive about her care. An interview was conducted with Resident #18's assigned Nurse Aide (NA) #1 on 06/10/22 at 1:12 PM. NA #1 revealed she had not known Resident	F 558	On 6/28/2022 observation walking rounds were completed by the Administrator for observing placement of call light for all current residents. All residents that can utilize a call light had the call light in place in order to obtain staff assistance. Those residents that cannot utilize a call light are checked frequently to assess their needs. The Department Managers are observing residents for accommodation of needs related to call lights and accommodation of needs related to activities of daily living care. The Director of Nursing and/or Administrator will track and trend the review. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/27/2022, The Director of Nursing began educating all clinical staff to include full-time part-time, PRN and agency nurses and nurse aides on the following • Accommodation of resident needs to include ensuring call light is within resident's reach Any clinical staff (full time, part time, PRN, and agency) who did not receive in-service training by 7/4/2022 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation.	

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F 558	Continued From page 17 #18 to engage the call light and typically anticipated her needs. NA #1 revealed she hadn't noticed the call light had been out of reach and thought it was misplaced during care and forgotten to be placed within reach. An interview was conducted with the Administrator on 06/10/22 at 5:17 PM. The Administrator revealed she would expect call lights were within reach of the residents.	F 558	Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning 7/6/2022, The Director of Nursing, and/or designee will utilize the QA tool for Reasonable Accommodations to monitor call light placement. The Director of Nurses, and/or designee will monitor 5 residents weekly for 4 weeks, then monthly for 2 months to ensure call light is within resident's reach to call staff for assistance. This tool will be completed as stated above or until such time that the (Quality Assurance) QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director. Date of Compliance: 7/4/2022	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		7/4/22

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F 561	Continued From page 18 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide residents with their preferred method of bathing and number of showers per week (Residents #47, #38, #28, and #18) and failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #87) for 5 of 15 residents reviewed for choices and Activities of Daily Living (ADL). Findings included: 1. Resident #47 was admitted to the facility on 08/30/21 with multiple diagnoses that included	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F561- Self Dtermination	

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F 561	Continued From page 19 malignant neoplasm of the colon and anxiety. The quarterly Minimum Data Set (MDS) dated 04/11/22 assessed Resident #47 with moderate impairment in cognition. He required physical assistance of one staff member with part of the bathing activity and displayed no rejection of care during the MDS assessment period. Review of Resident #47's care plans, last reviewed/revised on 04/29/22, revealed a plan of care that addressed an ADL self-care performance deficit related to fatigue status post gastrointestinal surgery. Interventions included: allow me plenty of time to complete tasks, I require extensive assistance with dressing and undressing, offer me choices in my daily care, and I prefer showers. The Nurse Aide (NA) Master Shower Schedule (MSS) provided by the facility, dated 01/25/22, was reviewed. The MSS indicated the shower team assignments were scheduled for Monday, Tuesday and Wednesday and noted in bold. Resident #47 was scheduled to receive his showers on Wednesdays and Saturdays during the hours of 3:00 PM and 11:00 PM and was not listed in bold to indicate his showers would be completed by the shower team. Review of the NA bathing documentation reports provided by the facility for Resident #47 for the period April 2022 to June 2022 revealed the following: April: Showers were documented as provided on 04/02/22, 04/20/22, and 04/30/22. There were no bed baths documented as provided. May: Bed baths were documented as provided on 05/04/22, 05/05/22, and 05/28/22. There were	F 561	Corrective action for resident(s) affected by the alleged deficient practice: For residents #47, #38, #28, and #18, On, 6/10/2022, Nursing staff performed bed bath. Resident #87- On 6/9/2022 Nurse aide (NA) #4 assisted resident with getting dressed and out of bed- and up to wheelchair. Nurse manager updated resident time preference to get out of bed. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 7/1/2022 the Director of Nursing, assessed all current resident for accommodation of needs related to out of bed preferences and accommodation of needs related to ADL care. The resident preferences have been incorporated into each resident's plan of care and kardex so that staff providing care will be aware of resident care preferences. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/27/2022, The Director of Nursing began educating all clinical staff to include all full-time, part-time, PRN and agency nurses, medication aides, and nurse aides on the following: • Accommodation of resident needs to include bathing/showers and accommodating resident request related	

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F 561	Continued From page 20 no showers documented as provided. June: There was no bathing activity documented as provided. During an observation and interview on 06/06/22 at 11:18 AM, Resident #47 was sitting up in his wheelchair with visible beard stubble and no obvious body odor. Resident #47 was unaware how many showers he was scheduled to receive per week and could not recall when he last received a shower but stated he had not had one since his last doctor's visit over a month ago. Resident #47 voiced he preferred showers in lieu of a bed bath and would like to receive one shower per week on Friday evenings. During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #47's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall. During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #47's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided	F 561	to ADLs. Any clinical staff (nurse or nurse aide, or medication aide) full time, part time, PRN, and agency who did not receive in-service training by 7/4/2022 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation. Bathing to be to completed per resident preference and CarePlan updated to reflect resident preference. Resident preference to be discussed in quarterly CarePlan meeting. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: On 7/6/2022 The Director of Nursing or designee will begin monitoring compliance by interviewing or observing 5 residents utilizing the F-561Self-determination QA Tool. This is to be completed weekly x 4 monthly x 2. The Administrator will present the analysis of the tracking and trending of Self Determination to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of substantial compliance is maintained then quarterly.	

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F 561	Continued From page 21	F 561	Date of Compliance: 7/4/2022	

such as resident showers and documentation. NA #2 stated if she was able to provide some of the residents on her assignment with their scheduled showers, she chose the residents who had gone the longest without receiving a shower.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #47's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. The Administrator and DON both confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The DON explained the MSS was created to divide resident showers between the NAs and shower team, the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had an active Performance Improvement Plan (PIP) related to showers that they were still working on

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and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed.

During a follow-up interview on 06/10/22 at approximately 6:30 PM, the Administrator stated the Performance Improvement Plan related to showers was started on 02/01/22, last reviewed at a QAPI (Quality Assurance and Performance Improvement) meeting on 04/18/22 and was ongoing.

2. Resident #87 was admitted to the facility on 10/24/12 with multiple diagnoses that included cerebral infarction (stroke).

The quarterly Minimum Data Set (MDS) dated 05/11/22 assessed Resident #87 with moderate impairment in cognition. She required total staff assistance of two staff members with transfers and displayed no rejection of care during the MDS assessment period.

Review of Resident #87's care plans, last reviewed/revised on 05/25/22, revealed a plan of care that addressed an altered ADL self-care performance deficit and altered mobility status with low activity intolerance. Interventions included: required total assistance of 2 staff members with transfers using a mechanical lift and totally dependent on staff for lower body dressing.

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During an interview on 06/06/22 at 10:45 AM, Resident #87 revealed she engaged her call light this morning at 7:00 AM to request staff assistance with getting up out of bed and into her wheelchair. She could not recall the exact time her call light was answered but indicated the staff member turned off the call light, stated they were busy and would be back to assist her out of bed before lunch. Resident #87 voiced she preferred to be up out of bed right after breakfast but usually did not get assistance until mid-morning or just before lunch.

A follow-up interview and observation was conducted with Resident #87 on 06/08/22 at 10:25 AM. Resident #87 was lying in bed and stated she had engaged her call light to request assistance to get out of bed but staff had turned it off. Resident #87 voiced she did not like lying in bed until noon and wanted to up in her wheelchair so she could go out into the facility. Resident #87 stated she felt "isolated and forgotten about" when left in the bed.

During an interview on 06/09/22 at 2:27 PM, Nurse Aide (NA) #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA #2 confirmed Resident #87 preferred to be up out of bed after breakfast and she tried her best to accommodate her preference but when she was the only NA assigned to the hall, it might take her a little longer to provide assistance.

During an interview on 06/09/22 at 4:41 PM, NA #6 revealed she was routinely assigned to Resident #87's hall with anywhere from 20 to 27 residents on her assignment. NA #6 explained

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when short-staffed and assigned 20 or more residents, she focused on keeping the residents safe, dry and fed. NA #6 confirmed Resident #87 preferred to be up out of bed right after breakfast and would yell out for staff if they were not there to assist her right when she expected.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The Administrator and DON both stated they would never want any resident to feel "isolated or forgotten about" and were not aware Resident #87 felt that way. The DON agreed Resident #87 should be assisted out of bed at her preferred time of day and explained it was likely the NA was waiting on another staff member to assist them with transferring Resident #87 since she required the use of a mechanical lift for transfers. The DON stated a resident's preference should be accommodated if at all practicable.

3. Resident #28 was admitted to the facility on 09/14/20 with diagnoses including dementia.

The quarterly Minimum Data Set (MDS) dated 03/25/22 assessed Resident #28 was cognitively intact. Resident #28 required extensive assistance with personal hygiene and physical assistance by 1-person with bathing. The MDS also indicated Resident #28 had no rejection of care behaviors during the lookback period.

Resident #28's care plan identified her as having a self-care deficit related to limited mobility, impaired vision, and needed extensive assistance

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for activities of daily living. The goals included Resident #28 would receive assistance from staff with all aspects of daily care to ensure her needs were met. Interventions initiated on 09/16/20 included staff to assist with personal hygiene and indicated Resident #28's bathing preference was to receive showers.

Review of the Nurse Aide staff documentation from March through June 2022 revealed Resident #28's showers were scheduled on Tuesday and Friday during day shift. Based on the recorded showers one shower had been given on 04/26/22.

During an interview on 06/09/22 at 10:35 AM Resident #28 revealed her shower days were scheduled on Tuesday and Friday but she couldn't remember when her last shower was given. Resident #28 revealed when she doesn't get a shower, she doesn't get a bed bath either. Resident #28 revealed she had to ask Nurse Aide (NA) staff for help wiping her off and used the bathroom sink to clean her face. Resident #28 stated she wanted her showers as scheduled and it use to be the NA would give her shower regularly but that doesn't happen anymore. Resident #28 revealed she had given up on asking about her showers and stated nothing was done when she did. Resident #28 revealed the facility does have staff that come to give showers but if you weren't on their list, you didn't get one.

An interview was conducted on 06/07/22 at 03:30 PM with NA #1. NA #1 was assigned to work on 06/06/22 on the hall Resident #28 resided. NA #1 revealed she was scheduled to work on day shift and had worked for the facility approximately one year. NA #1 revealed on 06/06/22 she was assigned 28 residents along with two nurses and

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stated she didn't even look at which residents were scheduled a shower. NA #1 stated staffing was horrible, and her typical assignment was 20 or more residents, and she does what she can to provide care. NA #1 revealed she does try to give a bed bath by wiping down the residents face, under arms, and peri-area. NA #1 revealed the facility tried to keep five NA staff scheduled which gave each approximately 20 to 21 residents but that didn't always happen. NA #1 revealed the shower team does a lot of the residents showers who require 2-person assistance with bathing.

An interview was conducted on 06/10/22 at 5:34 PM with the Administrator and Director of Nursing (DON). It was shared Resident #28 didn't receive consistent bathing on the days her preferred showers were scheduled. The Administrator stated they recognized residents not receiving their showers was a concern and implemented a shower team in January 2022. The DON revealed the shower team comes 3 to 4 days a week and one staff on Sunday to do showers. The Administrator revealed with showers being an ongoing concern additional support staff were hired including paid feeding assistants. The Administrator stated the facility was ongoing to address missed showers and ask NA staff communicate if they couldn't provide a resident's shower. The Administrator stated she may be looking into extending the shower teams hours.

4. Resident #38 was admitted to the facility 05/10/10 with diagnoses including stroke.

Review of the annual Minimum Data Set (MDS) dated 04/09/22 revealed Resident #38 was cognitively intact and required physical assistance of one staff member with part of the bathing

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activity. The MDS indicated Resident #38 had no rejection of care during the lookback assessment period.

Review of the activities of daily living (ADL) care plan last updated 04/09/22 revealed Resident #38 required extensive assistance with bathing.

The Nurse Aide (NA) Master Shower Schedule (MSS) revealed Resident #38 was scheduled to receive her showers on Mondays and Thursdays during the hours of 03:00 PM to 11:00 PM. The MSS indicated the shower team was scheduled to perform Resident #38's shower on Mondays. Resident #38's showers for Thursdays were not scheduled to be completed by the shower team.

Review of NA bathing documentation reports provided by the facility for Resident #38 for May 2022 and June 2022 revealed the following:

May: A shower was documented as being provided on 05/02/22. Bed baths were documented as being provided 05/03/22, 05/14/22, and 05/18/22.

June: A bed bath was documented as being provided 06/03/22. A shower was documented as being provided 06/06/22.

An interview with NA #1 on 06/07/22 at 03:30 PM revealed she usually worked the 07:00 AM to 03:00 PM shift but also worked the 03:00 PM to 11:00 PM shift at times and cared for Resident #38. She stated there were times when she was assigned 28 residents. NA #1 stated when she was assigned that many residents she was unable to provide showers as scheduled. She stated she would try to provide a bed bath when

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she knew she was not going to be able to provide a shower. NA #1 stated the nurses were aware that showers often did not get done as scheduled.

An interview with NA #8 on 06/09/22 at 02:00 PM revealed she worked the 03:00 PM to 11:00 PM shift and frequently cared for Resident #38. She stated there were times when there were only 3 to 4 NAs for the entire 03:00 PM to 11:00 PM shift (she was unable to provide an exact number of residents on her assignment when there only 3 to 4 NAs for the entire facility) and when staffing was that short she had to prioritize care, by ensuring by residents received incontinence care and feeding assistance. NA #8 stated she documented that a shower was given if she was able to provide a shower, but there were frequently times when she was not able to get scheduled showers done and if she was unable to provide showers she notified the nurse.

An interview with Resident #38 on 06/09/22 at 06:02 PM revealed she was supposed to receive 2 showers a week and she often did not receive her showers. She stated she preferred showers over bed baths and would like to receive 2 showers a week.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 05:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed an issue had been identified with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility certain nights of the week to give residents showers. The DON explained the MSS

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F 561	Continued From page 29 was created to divide resident showers between NAs and shower team and the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had an Active Performance Improvement Plan (PIP) related to showers that they were still working on and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed. During a follow-up interview on 06/10/22 at approximately 06:30 PM, the Administrator stated the PIP related to showers was started on 02/01/22, was last reviewed at a Quality Assurance and Performance Improvement (QAPI) meeting on 04/18/22, and was ongoing.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		7/4/22

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F 578	Continued From page 30 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate advanced directives for 1 of 36 residents (Resident # 309) reviewed for advanced directives. The findings included: Resident #309 was admitted to the facility on	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	

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F 578	Continued From page 31 5/20/22. Her diagnoses included right femur fracture and history of falls. Review of Resident #309's physician orders revealed an active order for full code effective 5/20/22. On 6/7/22 at 11:35AM a review of the facility Code Book located in the nurses' station revealed a Do Not Resuscitate form for Resident #309. The form was effective 5/23/22, without an expiration date and signed by the Medical Director. Resident #309's admission Minimum Data Set (MDS) was dated 5/27/22 and indicated she was cognitively intact for daily decision making. In an interview with Nurse #4 on 6/7/22 at 2:05PM, she stated if she needed to know the code status of a resident she would go to the Electronic Medical Record (EMR) and view the Physician orders or she would refer to the code book at the nurses station. She stated Resident #309 had a full code order in her EMR and a conflicting DNR order form in the facility Code Book. She indicated if a resident went into cardiac arrest, she would refer to the information that was closest and most easily accessed. In a subsequent interview with Nurse #4 on 6/7/22 at 2:18 PM, she stated the Admission Coordinator verified the resident's code preference and sent an email to the unit secretary on 5/23/22 that stated Resident #309 wanted to be Do Not Resuscitate (DNR). Nurse #4 revealed that the DNR form was completed, signed by the Medical Director, and placed in the Code Book but a new order to delete the full code	F 578	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F578 REQUEST/ REFUSE/DISCONTINUE TRMNT; FORMLTE ADV DIR Corrective action for resident(s) affected by the alleged deficient practice: Regarding the alleged deficient practice of failure to clarify code status for resident #309. On 6/10/22, Assistant Director of Nursing (ADON) received an order a DNR (Do Not Resuscitate) order from the MD for the resident #309 per the resident's preferences. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current facility residents have the potential to be affected by the alleged deficient practice of failure to clarify code status. On 6/10/22 the Health Information Manger (HIM) completed a 100% audit of Advanced Directives for all current residents within the facility to validate Advanced Directive form, Physician orders and the canary transport form are consistent and available in the resident's chart. No additional concerns with resident code status were identified. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 578	Continued From page 32 order and replace it with a DNR order was not entered into the EMR. In an interview with the Director of Nursing (DON) on 06/08/22 at 11:45 AM, she stated the Admissions Department confirmed the resident's code status on admission and then communicated the directive to the nursing unit secretary in an email. The Unit Secretary confirmed the correct advance directive order is in the EMR and if the directive was DNR, she would send the Do Not Resuscitate order form to the doctor for signature. She indicated it was an error that Resident #309's EMR was not updated from full code to DNR. She stated the Code Book DNR orders should match the code status orders in the EMR. During an interview on 6/10/22 at 10:23 AM the Admissions Director revealed the facility process was the code status was confirmed by the Admissions office at the time of admission and the nursing department was notified via email to the Unit Secretary. She stated the nursing unit secretary was notified by email on 5/23/22 that Resident #309 wanted to be DNR. During an interview on 6/10/22 at 12:38 PM, the nursing unit secretary stated when a resident was admitted the facility the admissions office will send an email with the resident's preference for code status. She stated that she received an email that Resident #309 wanted to be a DNR. She initiated the DNR order form for the Code Book for the medical director to sign, but she must have gotten busy, and she forgot to change the order in the EMR to DNR. In an interview on 6/10/22 at 12:47 PM the	F 578	The DON and/or the ADON provided in service education for the licensed nursing staff and social workers regarding completion of Advanced Directives upon admission to include Advanced Directives form, Physician order and the canary transport form completed by July 4, 2022. The Licensed Nurses or the Admissions liaison will assist the resident and/or the family to complete the Advanced Directive form upon admission. If the resident wishes are for a Do not resuscitate (DNR), the Physician will be notified and an order written to support the resident wishes, and the canary transport form will be completed and signed by the physician. The forms will be placed in the resident’s medical record upon completion. The Physicians order will be included in the order section of the resident’s electronic medical record. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 7/6/2022, The Health Information Manger will complete a random audit of five (5) resident records to ensure that the code status order was obtained and accurate based on the resident preference. This audit will be completed weekly x4 then monthly x 2. QA (Quality Assurance) Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing	

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F 578	Continued From page 33 Administrator stated it was her expectation that the advance directive order in the EMR matched the DNR order sheet located in the Code Book.	F 578	concerns is initiated as appropriate for compliance with regulatory requirements. Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting. Date of Compliance: 7/4/2022	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		7/4/22

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F 583	Continued From page 34 provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the Private Health Information (PHI) for 1 of 1 sampled resident (Resident #9) by leaving confidential medical information unattended in an area visible and accessible to the public on 1 of 2 medication carts on Barclay Hall. The findings included: Resident #98 was admitted to the facility on 01/30/22. A continuous observation was made on 06/06/22 from 12:58 PM to 1:04 PM of an unattended computer on a Barclay medication cart. Nurse #5 left the medication cart with the computer screen visible as she walked down the hall and entered another resident's room. Resident #98's PHI, which included picture, room number and list of medications, was visible to anyone that passed by, including those not authorized to view the confidential information. During an interview on 06/06/22 at 61:22 PM, Nurse #5 confirmed she left Resident #98's PHI visible on the computer screen when she left the medication cart to walk down the hall to another resident's room. Nurse #5 verified she had received Health Insurance Portability and	F 583	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F583 Personal Privacy/Confidentiality of Records Corrective action for resident(s) affected by the alleged deficient practice: On 6/6/2022, the Director of Nursing reeducated Nurse# 5 related to protecting resident health information at all times and computer screens should have privacy button clicked or laptop closed prior to walking away from screen. Corrective action for residents with the potential to be affected by the deficient practice:	

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F 583	Continued From page 35 Accountability Act (HIPAA) training and normally minimized the screen when leaving the cart unattended but just forgot. During an interview on 06/07/22 at 2:15 PM, the Director of Nursing (DON) stated all nursing staff received HIPPA training which included not leaving computer screens unattended with resident confidential information visible. The DON stated she would have expected Nurse #5 to minimize the computer screen before leaving the medication cart unattended.	F 583	All residents have potential to be affected by the deficient practice. On 6/7/2022, the Staff Development Coordinator (SDC) completed an audit by rounding throughout the facility to observe for potential issues related to leaving confidential medical information unattended. No issues noted during rounds. Systemic Changes: On 6/27/2022, the Director of Nursing began educating all licensed nurses and medication aides related to resident privacy and the right to secure and confidential personal and medical records. The Director of Nursing will ensure that any clinical staff including new hires and agency staff who has not received this training by will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and medication aides who utilize EMAR in the facility. Quality Assurance: On 7/6/2022, Director of Nursing or designee will monitor this issue using the Survey Quality Assurance (QA) Tool for Monitoring Confidentiality of Records.	

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F 583	Continued From page 36	F 583	The monitoring will include observing medication carts on halls to ensure resident personal and medical record is protected. This will be completed 5 x weekly for 4 weeks then monthly x 2 months or until resolved by to ensure their needs are met. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 7/4/2022	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would	F 622		7/4/22

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otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

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F 622	Continued From page 38 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, Resident Representative, Ombudsman and staff interviews, the facility failed to allow residents to remain in the facility for 2 of 4 sampled residents reviewed for facility initiated transfers and discharges (Residents #157 and #156). The findings included:	F 622	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	

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F 622	Continued From page 39 1. Resident #157 was admitted to the facility on 01/26/22 with diagnoses that included cervical myelopathy (compression of the spinal cord in the neck), cardiomyopathy (heart muscle disease), and unspecified systolic (congestive) heart failure. Review of the facility's Admission Packet revealed an undated letter signed by the Social Worker (SW) that read in part, "Our goal throughout your stay is to provide quality care rehabilitation, and safe discharge plan following completion of rehabilitation ...Should a resident or family wish to pursue a discharge location other than home, the SW can assist in finding placement in a long-term care or assisted living facility, depending on which setting is most appropriate." Review of Resident #157's face sheet (document containing a resident's personal information such as the name and contact number of individuals the facility should notify in the event of an emergency or change in condition) noted her spouse was listed as her Responsible Party (RP). The admission Minimum Data Set (MDS) assessment dated 02/02/22 assessed Resident #157 with intact cognition. She had impairment on both sides of the upper and lower extremities and required total assistance with all activities of daily living. The MDS noted Resident #157 participated in the assessment and indicated it was her expectation to return to the community. Review of Resident #157's electronic medical record and hard copy documentation revealed the following documents related to discharge: On 02/15/22, the Business office issued a Notice of Medicare Non-Coverage (NOMNC) indicating	F 622	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F622 Transfers and Discharge Requirements Corrective action for resident(s) affected by the alleged deficient practice: For resident #156 and #157 Resident is no longer here to correct alleged deficient practice of appropriate transfer and discharge requirements. Corrective Action for Potentially Affected Residents: All current residents in the facility have the potential to be affected have the potential to be affected by the alleged deficient practice. On 6/29/2022, the Social Worker completed audits for all residents transferred/discharged from 6/15/22 forward to ensure transfers and discharge were processed per facility policy. No transfer/discharge issues noted. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/29/2022, the Administrator educated the Social Worker, Admissions Coordinator and Business Office Manager on Facilities Transfer and Discharge Policy which includes the transfer/discharge requirements. Any newly hired staff into these roles will be receive education during orientation. Any	

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F 622	Continued From page 40 the last covered day was 02/17/22 to Resident #157's spouse who decided to appeal. The spouse did not appeal in a timely manner and the appeal was denied. The spouse stated to the Business Office and Social Worker (SW) several times they did not have the funds to pay any copays or pay privately for her to admit to a long-term facility. On 02/28/22, a Notice of Transfer/Discharge (NTD) initiated by the facility revealed Resident #157 would be discharged home on 03/30/22 and the reason marked for the discharge was "you have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility." On 03/11/22, Resident #157 was approved for Medicaid. Notice of discharge was rescinded. SW and Administrator met with the resident and her spouse to discuss options. Both expressed frustration with the facility and were still seeking placement elsewhere. On 03/15/22, a bed offer was received from another skilled nursing facility. Resident #157 was noted as agreeable to discharge to the facility. A North Carolina Department of Health and Human Services (NC DHHS) Notice of Hearing letter dated 03/16/22 revealed a request for a hearing regarding the discharge of Resident #157 was received and indicated the hearing would be held on 04/13/22 at 10:00 AM. A Nurse Practitioner discharge summary progress note for Resident #157 and dated 03/17/22 read in part, "Overall, Resident #157's day has been uneventful with no major setbacks. Resident #157 did participate in therapy, has met inpatient rehabilitation goals, and is ready to discharge from rehabilitation to another skilled nursing facility."	F 622	staff identified above who does receive education by 7/4/2022 will not be allowed to work until education is completed. Monitoring Process: The Administrator or designee will monitor this issue using the Quality Assurance Tool for Monitoring Transfers and Discharges. The monitoring will include reviewing a sample of residents to ensure transfer/discharge completed per facility policy. This will be completed weekly x 4 weeks, then monthly x 2 months or until resolved to ensure medications are administered without delay. Reports will be presented weekly by the Administrator to the Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, Minimum Data Set (MDS) Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director. Date of compliance: 7/4/2022	

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A nurse progress note dated 03/18/22 revealed Resident #157 discharged to another skilled nursing facility on 03/18/22 at 2:00 PM via facility transport.
A NC DHHS Notice of Dismissal letter dated 03/25/22 revealed the hearing scheduled for 04/13/22 concerning Resident #157's discharge from the facility was dismissed due to receiving notification on 03/21/22 that the facility rescinded the NTD issued on 02/28/22.

Resident #157 was unable to be interviewed during the survey.

During an interview on 06/07/22 at 11:05 AM, the Ombudsman revealed they had several discussions with Resident #157's spouse regarding her discharge from the facility. The Ombudsman stated once Resident #157's Medicaid was approved, Resident #157's spouse stated they were both informed by the facility's SW there were no available long-term beds and she would have to transfer to another skilled nursing facility. The Ombudsman explained that Resident #157's spouse visited the resident daily as this facility was in close proximity to his home, but a new facility that was further away would make visiting more difficult. She further explained the spouse expressed the SW had not given the option to remain in this facility long term and insisted that the resident had to transfer to another facility. The Ombudsman revealed the spouse expressed that Resident #157 eventually agreed to the transfer because she had no other options as the SW "wore her down."

During an interview on 06/10/22 at 3:26 PM, the Accounts Receivable (AR) staff member recalled having multiple conversations with Resident

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#157's family member about their balance and Medicaid process. The AR staff member explained Resident #157 had applied for Social Security (SS) benefits prior to applying for Medicaid and the SS benefits would have to be approved before the Medicaid, which was one of the reasons the process took so long. She indicated she was unaware of the exact date that the Medicaid application was first submitted. She added in order to assist Resident #157's family member, she personally called the Medicaid main office to explain the situation with the hopes the Medicaid approval process would be expedited. The AR staff member stated during their conversations the family member was clear about their inability to take Resident #157 home or having the financial resources to pay for her stay at the facility.

During an interview on 06/10/22 at 9:47 AM, the SW revealed the facility had 8 resident halls, 5 were designated for long-term care and 3 were designated for short-term rehabilitation. The SW explained residents and/or their Resident Representative (RR) were informed upon admission if there were any long-term beds available at that time and within 3 days of their admission to the facility, she met with them to explain her role, discuss discharge plans, and answer any questions. She added if during the short-term stay it was determined long-term placement was needed and there were no long-term beds currently available at the facility, she informed the resident and/or their RR, provided them with a list of skilled nursing facilities in the area along with contact numbers and assisted them with finding alternate placement.

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This interview with the SW continued. The SW recalled Resident #157 was admitted to the facility for short-term rehabilitation and she had spoken with both Resident #157 and her spouse shortly after her admission. The SW stated during the initial conversation with Resident #157 and her spouse, the spouse expressed he would not be able to care for Resident #157 at home. She reported Resident #157 previously resided at home with her spouse as the primary caregiver. She indicated that because Resident #157 required assistance with all activities of daily living and a mechanical lift for transfers the spouse was unable to provide the level of care she needed. She explained to them both when Resident #157 completed her rehabilitation stay at the facility, she would assist them with finding another skilled nursing facility for Resident #157 to transfer for long-term care. She indicated when the resident's Medicare part A days ended there were no long-term care beds available for the resident to transfer to a semi-private room within the facility. When asked if the resident had the option to remain in the rehabilitation bed until a long term care bed became available, she provided no answer. The SW stated at the time she was seeking placement at another nursing facility for Resident #157 when she was discharged from Medicare part A (2/17/22), the resident had no payor source, her Medicaid application was pending, and she was accruing a balance that couldn't be paid. The SW recalled Resident #157 was a "very high-level of care" and she submitted referrals to at least 25 facilities with only a few willing to offer a bed due to Resident #157's Medicaid application still pending and no other payor source. The SW discussed the options for placement with both Resident #157 and her spouse and recalled Resident #157 was

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agreeable to the transfer but her spouse felt the facility was too far of a drive.

During interviews on 06/10/22 at 12:09 PM and 4:13 PM, the Administrator clarified when a resident admitted to the facility for short-term rehabilitation and it was later determined they would need long-term placement, whether or not the resident could remain in the facility would depend on the facility being able to meet the resident's needs and what their payor source was at the time. The Administrator confirmed the resident could remain in the short-term private room until a semi-private room was available. The Administrator recalled when Resident #157 received the Notice of Medicare Non-Coverage (NOMNC) on 02/15/22 indicating Medicare days would be ending on 02/17/22, Resident #157 did not have a payor source available, the Medicaid application process had not yet been started and the spouse was not willing to pay the bill that was accruing. She stated at one point, Resident #157's spouse offered to pay $50.00 toward the balance but then stated he couldn't afford to pay even that and a 30-day discharge notice was issued by the facility on 02/28/22. The Administrator stated Resident #157's Medicaid was finally approved on 03/11/22 and covered Resident #157's stay back to 02/01/22. Both she and the SW spoke with Resident #157 and the spouse but by that point, she recalled they were both unhappy and wanted to proceed with the transfer to another skilled nursing facility. The Administrator was asked if she was aware that a discharge notice with nonpayment as the basis for the discharge was not an acceptable discharge reason when Medicaid was pending. She indicated that at the time, the discharge notice was provided (02/28/22) the Medicaid

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application had not been submitted. She was unable to provide the date the Medicaid application was submitted but confirmed it was approved on 03/11/22.

2. Resident #156 was admitted to the facility on 05/02/22 with diagnoses that large cell lymphoma, left heel ulceration, urinary tract infection, and anxiety.

A Nurse Practitioner's (NP) progress note dated 05/03/22 revealed Resident #156 was admitted for rehabilitation following hospitalization and read in part, "has been admitted in attempt to help Resident #156 with transfers and mobility. Resident #156 is anxious regarding this and believes this will be futile (useless) within a 2-week timeframe as described by the hospital and states she is unable to bear weight at all. Currently she uses a mechanical lift for transfers and her husband is limited in providing care. She is anxious to start chemotherapy but will need to be able to improve her mobility in order to follow-up with outpatient oncology. Resident #156 without significant outside support." The diagnosis and assessment read in part, "Resident #156 has received one cycle of R CHOP (chemotherapy regimen for treating lymphoma) and is scheduled with the Oncologist (physician who specializes in the treatment of cancer) for a follow-up on 05/23/22. Chemotherapy currently on hold secondary to rehabilitation admission. Filgrastim (medication used to treat neutropenia (low white blood cells) caused by cancer medications) 480 micrograms ordered subcutaneously daily times 5 days currently on hold."

A NP discharge summary progress note dated

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05/04/22 read in part, "Resident #156 was evaluated by therapy; however, therapy plan not instituted secondary to left foot pain and lymphedema (swelling caused by fluid build-up in the arms or legs due to lymphatic blockage). Resident #156 was informed during hospitalization that therapy would involve two weeks with a goal for her to ambulate. Therapy realistically in this time frame would likely be able to improve mobility and transfers; however, ambulation would require additional time. Her insurance/facility require chemotherapy to be held during this time. Resident #156 anxious to start chemotherapy and follow-up with Oncology. She is requesting transfer to a facility in close proximity to her home and cancer center."

The 5-day/Discharge Return not Anticipated Minimum Data Set (MDS) assessment dated 05/05/22 assessed Resident #156 with intact cognition. The MDS noted the resident's discharge expectations were to discharge to another facility.

A nursing note dated 05/05/22 revealed Resident #156 was transferred to another skilled nursing facility via medical transport.

During a telephone interview on 06/08/22 at 2:57 PM, Resident #156's Resident Representative (RR) revealed Resident #156 was admitted to the facility on 05/02/22 to receive therapy services while starting chemotherapy in the area with the plans for her to eventually return home. On 05/03/22, the RR came to the facility and spoke with whom he believed was the Social Worker (SW) to inquire on her rehabilitation plans, was told facility staff were currently discussing it in a meeting and she (SW) would follow-up with them

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after the meeting. As he was speaking to the SW, the RR recalled hearing someone voice concerns over the cost of the chemotherapy medicine but did not know who. The RR stated later that morning (05/03/22), while in the room with Resident #156, the SW came into the room and informed them both Resident #156 would need to transfer to another facility no later than 05/05/22 but never gave them a reason as to why or what facility she would be transferring to. After leaving the facility on 05/03/22, the RR stated they contacted a facility closer to their home who had an available bed and made arrangements for Resident #156's transfer. The RR stated they were initially under the impression Resident #156 would remain at the facility for approximately 2 weeks and it was never their intention or request for her to transfer to another skilled nursing facility so soon.

During an interview on 06/10/22 at 9:47 AM, the SW recalled the day after Resident #156 admitted to the facility on 05/03/22, facility staff and NP were discussing plans for her chemo treatments, therapy services and what would be best for Resident #156. The SW did not recall speaking to Resident #156 or her RR on 05/03/22 but did recall speaking to them on that following Wednesday (05/04/22) or Thursday (05/05/22) after receiving a call from another skilled nursing facility informing her Resident #156's RR wanted her transferred because the facility was "kicking them out." The SW stated she was "caught off guard" by the phone call and went to Resident #156's room to discuss the phone conversation with them both. The SW stated she never informed them Resident #156 could not remain at the facility and explained it was the decision of Resident #156 and her RR for her to transfer to

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F 622	Continued From page 48 another skilled nursing facility. During an interview on 06/10/22 at 12:09 PM, the Administrator revealed they were aware of Resident #156's plans for rehab services and chemotherapy upon her admission to the facility and had already started with a treatment plan. The Administrator stated neither she, the SW, or any member of the team ever informed Resident #156 or her RR they could not remain at the facility.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of wandering behavior, pressure ulcers, discharge, and restraints for 5 of 34 sampled residents reviewed for MDS accuracy (Residents #66, #71, #105, #16, and #79). Findings included: 1. Resident #66 was admitted to the facility on 02/26/21 with multiple diagnoses that included anxiety and depression. The quarterly MDS assessment dated 04/25/22 assessed Resident #66 with moderate impairment in cognition. He required extensive assistance of one staff member with locomotion off the unit and wandered daily during the MDS	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F641 Accuracy of Assessments Corrective action for resident(s) affected by the alleged deficient practice: For resident # 66 corrective action was	7/4/22

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F 641	Continued From page 49 assessment period. Review of the staff progress notes for Resident #66 for April 2022 revealed no documented entries of wandering behavior. On 06/06/22 at 11:59 AM, Resident #66 was observed lying in bed, alert and well-groomed. Resident #66 would not verbally respond during conversation and made no attempts to get up out of bed unassisted. On 06/07/22 at 08:31 AM, Resident #66 was observed well-groomed, sitting in his wheelchair in the dining room/common area eating his breakfast. On 06/07/22 at 9:28 AM, Resident #66 was observed sitting in his wheelchair in the dining room/common area, watching staff as they walked down the hall. During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) revealed she was responsible for completing the MDS section related to behaviors. The SW confirmed she completed Resident #66's MDS assessment dated 04/25/22 and explained when she coded wandering as occurring daily for Resident #66, she based that off his normal behavior which was to propel throughout the halls of the facility. The SW confirmed the MDS was coded inaccurately for wandering and should have reflected he had no wandering behavior during the MDS assessment period. During an interview on 06/10/22, the Administrator explained Resident #66 liked to propel throughout the facility and did not	F 641	obtained on 06/27/22 by modifying and correcting the Minimum Data Set (MDS) assessment for assessment reference date (ARD) 4/25/22. Modification was to reflect that resident #66 did not wander daily during the seven day specified lookback timeframe. Corrected Minimum Data Set (MDS) assessment was resubmitted to the state and accepted on 6/28/22. For resident # 71 corrective action was obtained on 6/27/22 by modifying and correcting the Minimum Data Set (MDS) assessment for assessment reference date (ARD) 4/26/22. Modification was to reflect that resident #71 had 1 stage II facility acquired pressure ulcer and 0 stage III pressure ulcers during the 7 day lookback. Minimum Data Set (MDS) assessment was resubmitted to the state and accepted on 6/28/22. For resident #79 corrective action was obtained on 6/27/22 by modifying and correcting the Minimum Data Set (MDS) assessment for assessment reference date (ARD) 5/11/11. Modification was to reflect resident #79 had a Deep Tissue Injury (DTI) on admission and present during the 7 day lookback. The Minimum Data Set (MDS) assessment was resubmitted to the state and accepted on 6/28/22. For resident #16 corrective action was obtained on 6/9/22 by modifying and correcting the quarterly Minimum Data Set (MDS) assessment for assessment	

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exit-seek, invade the privacy of other residents, or put himself in harm's way. The Administrator stated the MDS assessment dated 4/25/22 that indicated Resident #66 wandered daily was a coding error and it was her expectation for MDS assessments to be accurate.
2. Resident #71 was admitted to the facility on 08/20/19 with diagnoses including dementia.

Review of the Wound Care Nurse Practitioner (NP) progress notes dated 04/01/22, 04/08/22 and 04/15/22 revealed Resident #71 was assessed for a facility acquired right buttock stage 2 pressure ulcer.

Review of the physician orders for Resident #71 revealed on 04/01/22 a wound treatment was written for a stage 3 pressure ulcer on the right buttock. The order was discontinued on 04/15/22. A new physician order was written on 04/15/22 for a stage 2 pressure ulcer on the right buttock.

Resident #71 was discharge to the hospital on 04/26/22.

Review of Resident #71's discharge Minimum Data Set (MDS) assessment dated 04/26/22 identified two facility acquired pressure ulcers, one stage 2, and one stage 3.

During an interview on 06/10/22 at 2:50 PM MDS Nurse #2 confirmed she coded the discharge MDS dated 04/26/22. MDS Nurse #2 revealed she did not visually assess Resident #71's wounds or review the progress notes written by the Wound Care NP but only reviewed the physician orders. When she reviewed the physician orders written on 04/01/22 and 04/15/22 she determined Resident #71 had one reference date (ARD) 3/8/22. Modification was to reflect resident #16 did not use bedrail as a restraint less than daily during the 7 day lookback. The Minimum Data Set (MDS) assessment was resubmitted to the state and accepted on 6/10/22.

For resident #105 corrective action was obtain on 6/14/22 by modifying and correcting the Discharge Return Not Anticipated Assessment with Assessment Reference Date (ARD) 4/10/22 to reflect discharge was to community and not to the hospital. The Minimum Data Set (MDS) assessment was resubmitted to the state and accepted on 6/14/22.

Corrective action for residents with the potential to be affected by the alleged deficient practice:

All residents have the potential to be affected by the alleged deficient practice. An audit of selected residents who have had a Minimum Data Set (MDS) assessment completed during the past 90 days was completed in order to identify any potential coding deficiencies. This audit was conducted by the Clinical Reimbursement Consultant on 6/28/22.

Audits

10 Discharge assessments were reviewed with no discharge status or skin discrepancies

10 Admission assessments were reviewed with no skin discrepancies

10 Random OBRA and PPS assessments were reviewed with no

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stage 2 and one stage 3 pressure ulcer on the right buttock. She explained she coded the discharge MDS to reflect a stage 2 and stage 3 facility acquired pressure ulcer and at the time didn't see the discrepancy.

An interview was conducted on 06/10/22 at 4:01 PM with the Wound Care NP. The Wound Care NP stated Resident #71 did not have a stage 3 pressure ulcer prior to being discharged to the hospital and she provided treatment orders for a stage 2 pressure ulcer located on the right buttock.

An interview was conducted on 06/10/22 at 5:25 PM with Director of Nursing (DON). The DON revealed she would expect the MDS nurse review physician orders when coding. The DON also revealed she would expect the MDS coding to reflect Resident #71 had one stage 2 facility acquired pressure when discharge to the hospital.

3. Resident #105 was admitted to the facility 03/21/22 with diagnoses including diabetes mellitus and chronic respiratory failure.

The admission Minimum Data Set (MDS) assessment dated 03/28/22 revealed Resident #105 was admitted to the facility for rehabilitation with the goal to return home.

The Medical Doctor (MD) discharge summary revealed on 04/08/22 the MD physically assessed Resident #105, reviewed the list of medications, and provided a summary for plans to discharge home.

A physician's order written on 04/08/22 revealed Resident #105 was to be discharge home on

restraints coded

Systemic Changes:

On 06/30/22, the Clinical Reimbursement Consultant completed an in service training for the facility Minimum Data Set (MDS) nurses and the Social Worker that included the importance of thoroughly reviewing the medical record during the assessment process, reviewing orders and observing each resident before coding the Minimum Data Set (MDS) assessment. Special emphasis was placed on:

• It was detailed the importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes, physician orders and observing each resident during the seven day lookback for completion of Minimum Data Set (MDS) Assessment. This information is located in the Resident Assessment Instrument (RAI) manual in chapter 3 and has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

The Director of Nursing or designee will begin auditing the coding of MDS items utilizing the Accurate Coding of MDS Audit Tool provided.

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F 641	Continued From page 52 04/10/22. Review of the nurse progress note written on 04/10/22 revealed Resident #105 was approved to discharge and escorted to the discharge area to go home with a family member. The discharge MDS dated 04/10/22 revealed Resident #105 was discharge to the hospital and not expected to return to the facility. An interview was conducted on 06/10/22 at 2:45 PM with MDS Nurse #1. MDS Nurse #1 revealed he had signed the discharge MDS dated 04/10/22 for Resident #105. After reviewing the documentation MDS Nurse #1 stated Resident #105 had a planned discharge to go home and was not sent to the hospital. MDS Nurse #1 revealed a coding error was made and he would modify and resubmit the MDS to reflect the correct discharge status. An interview was conducted on 06/10/22 at 5:19 PM with the Director of Nursing (DON). The DON revealed it was her expectation the information on the MDS was coded correct for residents. The DON confirmed the discharge MDS should reflect Resident #105's discharge status to the community and was a coding error. 4. Resident #16 was admitted to the facility 08/13/21 with a diagnosis of hypertension (high blood pressure). Review of the quarterly Minimum Data Set (MDS) dated 03/08/22 revealed Resident #16 was cognitively intact, required supervision with bed mobility, and had a bed rail that was used as a restraint less than daily.	F 641	Quality Assurance: This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 7/4/2022	

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Review of Resident #16's care plan for positioning last updated 06/08/22 revealed she used grab bars while in bed to maintain as much independence with bed mobility as possible. Interventions included placing grab bars to both sides of the bed and providing an appropriate level of assistance with bed mobility.

An interview with MDS Nurse #2 on 06/09/22 at 03:35 PM revealed Resident #16's bed rails were not used as a restraint and that was a coding error. She stated she thought she just hit the wrong button when she coded the restraint section of the MDS and she would do a modification to reflect the bed rails were not used as restraints.

An interview with the Director of Nursing (DON) on 06/09/22 at 05:01 PM revealed the facility did not use restraints and Resident #16's MDS that reflected bed rails were a restraint was coded incorrectly. She stated she expected the MDS to be coded correctly.

An interview with the Administrator on 06/09/22 at 05:28 PM revealed the facility did not use restraints and Resident #16's MDS that reflected bed rails were a restraint was coded incorrectly. She stated she expected the MDS to be coded correctly.

5. Resident #79 was admitted to the facility on 5/4/22 with diagnoses including peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).

Resident #79's admission Minimum Data Set (MDS) dated 5/11/22 indicated Resident #79 did not have any pressure ulcers.

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F 641	Continued From page 54 Review of Resident #79's physician orders entered on 5/11/22 included treatment to the left heel deep tissue pressure area every shift. Review of Resident #79's Treatment Administration Record revealed the left heel deep tissue pressure ulcer treatment had been signed as completed by nursing staff starting on day shift 5/11/22. In an interview on 6/8/22 at 10:25 AM MDS Nurse #1 stated the deep tissue pressure ulcer on resident #79's left heel was identified on 5/11/22 and should have been reflected in her admission MDS dated 5/11/22. In an interview with the Administrator on 6/10/22 at 5:20 PM, she stated she expected the MDS assessments to be accurate.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		7/4/22

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F 644	Continued From page 55 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) review for a resident with a new mental health diagnosis for 1 of 2 sampled residents reviewed for PASRR (Resident #84). Findings included: Resident #84 was admitted to the facility on 10/30/21 with diagnoses that included non-traumatic brain dysfunction, Parkinson's disease, anxiety, depression, and schizophrenia. The admission Minimum Data Set (MDS) dated 11/06/21 revealed Resident #84 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. Review of the undated North Carolina Medicaid Uniform Screening Tool (NC MUST) document revealed Resident #84 had a Level 1 PASRR effective 04/19/21. Review of Resident #84's list of cumulative diagnoses contained in his medical record revealed a new diagnosis of "unspecified psychosis not due to a substance or known physiological condition" was added on 01/10/22. During an interview on 06/10/22 at 9:47 AM, the Social Worker (SW) revealed she was unaware	F 644	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F644 Coordination of PASARR and Assessment Corrective action for resident(s) affected by the alleged deficient practice: Resident #84 had a Level II PASRR submitted on 6/10/22 and was accepted. Corrective Action for Potentially Affected Residents: On 6/27/2022 Administrator began completing a 100% audit of current resident records to ensure that an appropriate PASARR number had been obtained for the residents within the review. No concerns with current resident Level II PASARR's were noted within the findings of this audit.	

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F 644	Continued From page 56 of the regulation requirement to request a PASRR review for any resident with a new mental health diagnosis. The SW confirmed she had not requested a Level II PASRR evaluation for Resident #84. During an interview on 06/10/22 at 12:09 PM, the Administrator confirmed knowledge of the regulation requirement to request a Level II PASRR review when a resident had a significant change in condition or new mental health diagnosis. The Administrator stated the SW would be the person responsible for requesting Level II PASRR reviews when indicated.	F 644	Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/30/2022, the Administrator completed education with all facility Social Workers, Health Information Manager, and Admissions Coordinators which included the PASARR assessment process and requirements for when a level II PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASARR. On 6/30/2022, Administrator made Health Information Manager aware of responsibility of notifying Social Workers of when a new diagnosis has been added that would potentially qualify a resident for a level II PASARR and made Social Worker aware of responsibility of requesting Level II PASRR reviews when indicated. Any Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 7/4/2022 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation. Quality Assurance:	

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F 644	Continued From page 57	F 644	On 7/6/22 The Administrator will compete an audit of new resident records for the need of a Level II PASARR screening. This audit will be completed weekly x4 then monthly x 2. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Administrator, Director of Nursing, Minimum Data Set Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting. Date of Compliance: 7/4/2022	
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	F 657		7/4/22

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F 657	Continued From page 58 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, staff and resident interviews, the facility failed to invite residents to participate and provide input in care plan meetings for 2 of 3 sampled residents (Resident #103 and Resident #79). This practice had the potential to affect other residents. Findings included: 1. Resident #103 was admitted to the facility on 3/30/22. Resident # 103's care plan was initiated on 3/31/22. The admission Minimum Data Set (MDS) dated 4/13/22 revealed Resident #103 was cognitively intact for daily decision making. Review of Resident #103's electronic medical record (EMR) revealed a care plan meeting signature sheet. This document indicated Resident #103's care plan meeting was held on 4/20/22 and was not signed by the resident. Review of Resident#103's progress notes revealed no documentation to indicate he had	F 657	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F657 Care Plan Timing and Revision Corrective action for resident(s) affected by the alleged deficient practice: Resident #79- resident has discharged. Resident #103- Care plan meeting scheduled on 7/20/22 and Social Worker invited residents/resident representative to attend this scheduled care plan meeting. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 657	Continued From page 59 been invited to his care plan meeting. During an interview on 6/06/22 at 10:53 AM, Resident #103 revealed he had not been invited to a care plan meeting. The Social Worker (SW) was interviewed on 6/10/22 at 9:47 AM. She revealed she prepared care plan invitation letters for the care plan meetings each week. The receptionist mailed the letters to the families and gave an invitation to alert and oriented residents. The SW indicated she and the receptionist had miscommunicated and Resident #103 did not receive an invitation to the care plan meeting. She stated Resident #103 should have been invited to attend his care plan meeting. An interview was conducted with the Administrator on 6/10/22 at 5:20 PM. She stated it was her expectation that residents were invited to attend care plan meetings. 2. Resident #79 was admitted to the facility on 5/4/22. Resident #79's care plan was initiated on 5/4/22. The admission MDS dated 5/11/22 revealed Resident #79 was cognitively intact for daily decision making. Review of Resident #79's electronic medical record (EMR) revealed a care plan meeting signature sheet. This document indicated Resident #79's care plan meeting was held on 5/25/22 and was not signed by the resident. Review of Resident #79's EMR revealed no	F 657	All current residents have the potential to be affected by the alleged deficient practice. On 6/27/2022, the Administrator audited 100% of resident scheduled for care plan meeting for the past 14 days beginning on 6/15/22. A care plan meeting is scheduled for all current residents. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/29/2022, the Administrator completed education related Care Planning Process with Social Worker, Administrative Nurses, and Minimum Data Set (MDS) nurses. Social Services will be responsible for notifying resident/resident representative of the date and time of the care plan meeting. The social worker will provide resident/responsible party with a letter explaining the care plan meeting and the date of the scheduled meeting. If a resident or their representative is not able to attend the meeting in person a phone call may be scheduled to discuss the resident's care. If the resident and/or resident representative does not attend the care plan meeting the social worker will document why they did not attend in the electronic health record using the care planning user-defined assessment (UDA). The Administrator will ensure that any Social Worker, Administrative Nurse, or MDS nurse who has not received this training by 7/4/2022 will not be allowed to work until the training is completed.	

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F 657	Continued From page 60 progress notes to indicate she was invited to her care plan meeting. During an interview on 6/06/22 at 4:08 PM, Resident #79 stated she had not been invited to a care plan meeting. The Social Worker was interviewed on 6/10/22 at 9:47 AM. She revealed she prepared care plan invitation letters for the care plan meetings each week. The receptionist mailed the letters to the families and gave an invitation to alert and oriented residents. The SW indicated she and the receptionist had miscommunicated and Resident #79 did not receive an invitation to the care plan meeting. She stated Resident #79 should have been invited to attend her care plan meeting. An interview was conducted with the Administrator on 6/10/22 at 5:20 PM. She stated it was her expectation that alert and oriented residents were invited to attend care plan meetings.	F 657	Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: On 7/6/22, The Administrator will observe 5 residents scheduled for Care Plan meeting us the F657 QA Tool for Monitoring Care Plan process to ensure resident or resident representative have been invited to participate in meeting. This will be done on weekly x 4 weeks then monthly for 2 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 7/4/2022	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		7/4/22

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F 677	Continued From page 61 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide showers or bed baths as scheduled for 4 of 13 sampled residents (Residents #46, #84, #87, and #85) reviewed for Activities of Daily Living (ADL). Findings included: 1. Resident #46 was admitted to the facility on 03/03/22 with diagnoses that included chronic atrial fibrillation (abnormal heartbeat), respiratory failure, chronic pain, and macular degeneration (eye disease that causes vision loss). The quarterly Minimum Data Set (MDS) dated 04/14/22 assessed Resident #46 with intact cognition. Resident #46 required physical assistance of one staff member, limited to transfer only, for bathing and displayed no rejection of care during the MDS assessment period. Review of Resident #46's care plans, last reviewed/revised on 04/29/22, revealed a plan of care that addressed an ADL self-care performance deficit related to gradual decline in physical function due to diagnoses of atrial fibrillation, back pain, and mild cognitive impairment. Interventions included: I require staff assistance with grooming and personal hygiene, extensive staff assistance required with transfers using stand/pivot method, and monitor/document/report to MD as needed any changes, potential for improvement, reasons for self-care deficit, and decline in function.	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F677 ADL Care Provided for Dependent Residents Corrective Action for Affected Residents: For resident# 46 bed bath provided by Certified Nurse Aide (CNA)on 6/9/2022. For resident #84 bed bath provide by CNA on 6/9/2022. For resident #85 bed bath provided by CNA on 6/9/2022. For resident# 87 bed bath provided by CNA on 6/9/2022. On 6/9/22 Nurse Manager verbally reeducated CNAs on Resident Rights and Shower Preferences. Corrective Action for Potentially Affected Residents: All residents who need assistance with bathing/showers have the potential to be	

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F 677	Continued From page 62 The Nurse Aide (NA) Master Shower Schedule (MSS) provided by the facility, dated 01/25/22, was reviewed. The MSS indicated the shower team assignments were scheduled for Monday, Tuesday and Wednesday and noted in bold. Resident #46 was scheduled to receive her showers on Mondays and Thursdays and was not listed in bold to indicate her showers would be completed by the shower team. Review of the NA bathing documentation reports provided by the facility for Resident #46 for the period April 2022 to June 2022 revealed the following: April: A shower was documented as provided on 04/02/22. Bed baths were documented as provided on 04/08/22 and 04/12/22. May: A shower was documented as provided on 05/05/22. Bed baths were documented as provided on 05/04/22 and 05/23/22. June: There was no bathing activity documented as provided. During an observation and interview on 06/06/22 at 11:50 AM, Resident #46 was sitting in her recliner, covered with a blanket, her hair was slightly disheveled but otherwise she appeared well-groomed with no obvious body odor. Resident #46 was unaware of how many showers she was scheduled to receive each week and reported only receiving one shower since her admission to the facility. Resident #46 did not recall receiving any bed baths. Resident #46 stated due to her risk of falls, she needed staff assistance and when she didn't receive her showers, she stated "sometimes it's like I can feel the dirt on my face and I just feel dirty."	F 677	affected by this alleged deficient practice. On 7/1/2022, Director of Nursing conducted resident interviews and have update bathing preferences, updated resident care plan and resident profile to reflect new bathing preference to provide the ADL care per resident preference. Systemic Changes: On 6/27/2022, Shower Team days increased to assist with performing showers. On 6/29/2022 the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's. This in-service included the following topics: • ADL Care & Documentation and Care Need Requirements • Resident Rights and Shower Preferences The Director of Nursing will ensure that any Full time, part time, as needed facility or agency Nurse or CNA who has not received this training by7/4/2022will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in- service refresher courses for all facility staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any	

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F 677	Continued From page 63 During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #46's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall. During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #46's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation. During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #46's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.	F 677	nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance; The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring ADL care. The monitoring will include reviewing a five (5) sample of to ensure bathing preferences are being met. This will be completed 3 times weekly x 2 weeks and weekly for 2 weeks then monthly times 2 months on varied shifts or until resolved by to ensure their bathing needs are met. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, minimum data set (MDS) Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 7/4/2022	

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A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. The Administrator and DON both confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The DON explained the MSS was created to divide resident showers between the NAs and shower team, the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had an active Performance Improvement Plan (PIP) related to showers that they were still working on and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed.

During a follow-up interview on 06/10/22 at approximately 6:30 PM, the Administrator stated the PIP related to showers was started on 02/01/22, last reviewed at a QAPI (Quality Assurance and Performance Improvement) meeting on 04/18/22 and was ongoing.

2. Resident #84 was admitted to the facility on 10/30/21 with multiple diagnoses that included

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wedge compression fracture of the vertebra, epilepsy (seizure disorder), and hypoxemia (low level of oxygen in the blood).

The quarterly Minimum Data Set (MDS) dated 05/09/22 assessed Resident #84 with intact cognition. He required extensive assistance of one staff member with part of the bathing activity and displayed no rejection of care during the MDS assessment period.

The Nurse Aide (NA) Master Shower Schedule (MSS) provided by the facility, dated 01/25/22, was reviewed. The MSS indicated the shower team assignments were scheduled for Monday, Tuesday and Wednesday and noted in bold. Resident #84 was scheduled to receive his showers on Wednesdays and Saturdays and was not listed in bold to indicate his showers would be completed by the shower team.

Review of Resident #84's care plans, last reviewed/revised on 04/15/22, revealed a plan of care that addressed an ADL self-care performance deficit related to activity intolerance and needing staff assistance to accomplish daily tasks safely due to right lower extremity weakness and new onset of seizures. Interventions included: allow me plenty of time to complete tasks, I require total staff assistance with transfers using a mechanical lift and monitor/document/report to MD as needed any changes, potential for improvement, reasons for self-care deficit, and decline in function.

Review of the NA bathing documentation reports provided by the facility for Resident #84 for the period April 2022 to June 2022 revealed the following:

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April: A shower was documented as provided on 04/27/22. There were no bed baths documented as provided.
May: Showers were documented as provided on 05/04/22 and 05/11/22. Bed baths were documented as provided on 05/05/22 and 05/23/22.
June: There was no bathing activity documented as provided.

During an observation and interview on 06/06/22 at 11:02 AM, Resident #84's hair was disheveled from lying in bed, had particles that appeared to be food stuck in his beard and the neck of his shirt was slightly stained. Resident #84 was unaware of how many showers he was scheduled to receive each week and reported he had not had a complete bed bath or shower in "months." Resident #84 stated staff would clean him up after a bowel movement but "not what he would consider a good wiping down."

During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #84's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall.

During an interview on 06/09/22 at 2:45 PM, NA

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#3 revealed she was typically assigned to Resident #84's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #84's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. The Administrator and DON both confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The DON explained the MSS was created to divide resident showers between the NAs and shower team, the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had

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an active Performance Improvement Plan (PIP) related to showers that they were still working on and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed.

During a follow-up interview on 06/10/22 at approximately 6:30 PM, the Administrator stated the PIP related to showers was started on 02/01/22, last reviewed at a QAPI (Quality Assurance and Performance Improvement) meeting on 04/18/22 and was ongoing.

3. Resident #87 was admitted to the facility on 10/24/12 with multiple diagnoses that included hemiplegia and hemiparesis (loss of strength or paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

The quarterly Minimum Data Set (MDS) dated 05/11/22 assessed Resident #87 with mild impairment in cognition. She required extensive assistance of one staff member with part of the bathing activity and displayed no rejection of care during the MDS assessment period.

The Nurse Aide (NA) Master Shower Schedule (MSS) provided by the facility, dated 01/25/22, was reviewed. The MSS indicated the shower team assignments were scheduled for Monday, Tuesday and Wednesday and noted in bold.

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Resident #84 was scheduled to receive her showers on Wednesdays and Saturdays. It was noted the shower team would provide her showers on Wednesdays during the hours of 3:00 PM to 11:00 PM and the NA would provide her showers on Saturdays.

Review of Resident #87's care plans, last reviewed/revised on 05/25/22, revealed a plan of care that addressed an altered ADL self-care performance deficit and altered mobility status related to hemiplegia and low activity intolerance. Interventions included: I required total assistance of 2 staff members with transfers using a mechanical lift and totally dependent on staff for lower body dressing.

Review of the NA bathing documentation reports provided by the facility for Resident #87 for the period April 2022 to June 2022 revealed the following:
April: A shower was documented as provided on 04/20/22. Bed baths were documented as provided on 04/09/22 and 04/11/22.
May: Bed baths were documented as provided on 05/04/22, 05/05/22, and 05/23/22. There were no showers documented as provided.
June: There was no bathing activity documented as provided.

During an observation and interview on 06/06/22 at 10:45 AM, Resident #87 was lying in bed and appeared well-groomed with no obvious body odor. Resident #87 stated she was supposed to receive two showers per week but did not get them regularly and whenever she asked staff for a shower, they would tell her they were short-staffed.

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During an interview on 06/09/22 at 2:27 PM, NA #2 revealed she had only been employed for about two months and since that time, staffing had been challenged. NA#2 stated she was typically assigned to Resident #87's hall as the only NA with anywhere from 18 to 28 residents on her assignment. NA #2 stated she could usually get scheduled showers provided if her assignment was 18 residents but any more than that, she had to prioritize resident care, such as meals and incontinence care, and showers would not get provided. NA #2 further stated this past week she was unable to provide any of her assigned residents with their scheduled showers due to being the only NA on the hall.

During an interview on 06/09/22 at 2:45 PM, NA #3 revealed she was typically assigned to Resident #87's hall with anywhere from 20 to 22 residents on her assignment and on some occasions, 28 residents. NA #3 explained when short-staffed and the only NA assigned to the hall, it was difficult to get all resident care provided such as resident showers and documentation.

During an interview on 06/09/22 at 3:17 PM, NA #4 confirmed residents had voiced complaints they had not received their showers. NA #4 explained she was assigned to Resident #87's hall during the months of April 2022 to June 2022 and typically had over 20 residents on her assignment which made it difficult to get all resident care done. NA #4 stated due to being short-staffed this past week, she was unable to provide residents with their scheduled showers but did try to provide them with a bed bath which she described as washing the face, underarms, and private areas.

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During an interview on 06/09/22 at 4:41 PM, NA #6 revealed was routinely assigned to Resident #87's hall with anywhere from 20 to 27 residents on her assignment. NA #6 explained when short-staffed and assigned 20 or more residents, she wasn't able to provide residents with their scheduled showers and focused on keeping the residents safe, dry and fed.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 5:16 PM. The Administrator and DON both confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed they had identified the issue with showers not being provided back in January 2022 and in response, a shower team was developed utilizing former employees who came to the facility on certain nights of the week to give residents showers. The DON explained the MSS was created to divide resident showers between the NAs and shower team, the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had an active Performance Improvement Plan (PIP) related to showers that they were still working on and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed.

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During a follow-up interview on 06/10/22 at approximately 6:30 PM, the Administrator stated the PIP related to showers was started on 02/01/22, last reviewed at a QAPI (Quality Assurance and Performance Improvement) meeting on 04/18/22 and was ongoing.

4. Resident #85 was admitted to the facility 12/19/18 with a diagnosis of non-Alzheimer's dementia.
The care plan for activities of daily living (ADL) last updated 05/03/22 revealed Resident #85 had an ADL self-care performance deficit related to weakness and chronic shoulder pain, required total assistance with transfers using a mechanical lift, and was to receive her showers Tuesdays and Fridays on the 07:00 AM to 03:00 PM shift.

Review of the quarterly Minimum Data Set (MDS) dated 05/09/22 revealed Resident #85 was severely cognitively impaired, was totally dependent for transfers, and required the physical assistance of one person in part of the bathing activity.

The Nurse Aide (NA) Master Shower Schedule (MSS) provided by the facility indicated Resident #85 was scheduled to receive her showers Tuesdays and Fridays during the 07:00 AM to 03:00 PM shift. The MSS indicated the shower team was scheduled to perform Resident #85's shower on Tuesdays. Resident #85's showers for Fridays were not scheduled to be completed by the shower team.

Review of NA bathing documentation reports provided by the facility for Resident #85 for May 2022 revealed a shower was documented as being provided 05/06/22, 05/10/22, and 05/24/22.

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It was documented Resident #85 refused a shower 05/29/22. Bed baths were documented as being provided 05/03/22, 05/04/22, 05/17/22, and 05/31/22.

An observation on 06/06/22 at 03:43 PM of Resident #85 revealed she was sitting up in her wheelchair and her hair appeared greasy.

An interview with NA #3 on 06/09/22 at 02:45 PM revealed she frequently worked with Resident #85 and her assignment was anywhere from 20 to 22 residents, with 28 residents on occasion. She stated when she had so many residents she could not get all her showers done. NA #3 stated when she was assigned that many residents she tried to focus on making sure residents were safe, received incontinence assistance, and had their call lights answered.

An interview with NA #7 on 06/10/22 at 03:03 PM revealed she worked with Resident #85 from time to time. She stated there were shifts when she was assigned 28 residents and she was not able to get showers done when she had that many residents to care for. NA #7 stated she had to prioritize care when she had such a heavy assignment and tried to focus on making sure residents were fed and received incontinence care.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 06/10/22 at 05:16 PM. Both the Administrator and DON confirmed the facility had faced staffing challenges and the hiring process was ongoing. The DON revealed an issue had been identified with showers not being provided back in January 2022 and in response, a shower team was

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F 677	Continued From page 74 developed utilizing former employees who came to the facility certain nights of the week to give residents showers. The DON explained the MSS was created to divide resident showers between NAs and shower team and the NAs could look at the schedule and if their assigned resident was not in bold lettering then they knew they would have to provide the resident with their scheduled shower. The Administrator added they also had an Active Performance Improvement Plan (PIP) related to showers that they were still working on and have asked staff to communicate when they were challenged with getting resident care done. The Administrator and DON both stated as part of the PIP, they monitored bathing documentation but could not explain why residents were still not receiving their scheduled showers. The Administrator and DON both stated they felt the provision of showers had improved since the issue was first identified and a shower team was developed. During a follow-up interview on 06/10/22 at approximately 06:30 PM, the Administrator stated the PIP related to showers was started on 02/01/22, was last reviewed at a Quality Assurance and Performance Improvement (QAPI) meeting on 04/18/22, and was ongoing.	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 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	F 684		7/4/22

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F 684	Continued From page 75 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician interviews the facility failed to provide services according to Physician orders for the care of a resident with lower extremity edema (swelling) for 1 of 5 residents reviewed for quality of care (Resident #85). Findings included: a. Resident #85 was admitted to the facility 12/19/18 with diagnoses including renal insufficiency (a condition where the kidneys don't filter properly), diabetes, and hypertension (high blood pressure). Resident #85 had a Physician order dated 09/01/21 for lasix (a diuretic) 20 milligrams (mg) 2 tablets one time a day for edema (swelling). Review of a Physician's progress note dated 03/17/22 revealed Resident #85 was seen for an acute visit per nursing request for multiple medical issues, including increased lower extremity edema. The progress note stated to continue lasix 40mg in the morning, add lasix 20mg in the evening, check baseline laboratory work, and monitor Resident #85 clinically. Resident #85 had a Physician order dated 03/17/22 for lasix 20mg one time a day in the evening for fluid. Review of Physician orders revealed an order for weekly weights dated 03/22/22.	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 Quality of Care Corrective action for resident(s) affected by the alleged deficient practice: For resident #85- On 6/9/2022, physician was notified and order given to discontinue weekly weights as weekly weights were no longer needed per physician. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 6/29/2022 the Director of Nursing completed an audit for all residents with orders for weekly weights to ensure their weekly weight were obtained as ordered by the physician. All weekly weights were in compliance. Weekly weights will continued to be monitored by the Director	

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F 684	Continued From page 76 Weights for April 2022 through June 2022 were as follows: 04/01/22 182 pounds 04/18/22 182 pounds 05/01/22 178.4 pounds 05/02/22 174.2 pounds 05/16/22 170.2 pounds 05/30/22 170 pounds 06/01/22 170 pounds Resident #85's weekly weight was blank on the April 2022 Medication Administration Record (MAR) for 04/04/22. Resident #85's care plan for hypertension last updated 05/03/22 revealed she was at risk for complications of hypertension and interventions included educating her family about the importance of maintaining a normal weight and administering antihypertensive medication as ordered. Review of the quarterly Minimum Data Set (MDS) dated 05/09/22 revealed Resident #85 was severely cognitively impaired, had not had any weight loss or weight gain, and received a diuretic 7 out of 7 days during the look back period. Review of April 2022, May 2022, June 2022 MARs revealed weekly weights were documented as "9" (which means other/see nurses' notes) on 04/11/22, 04/25/22, 05/09/22, 05/23/22, and 06/06/22. Review of the nurse's notes coded as "9" did not contain Resident #85's weights. An interview with Nurse #5 who worked with Resident #85 on 04/04/22, 04/11/22, 04/25/22, 05/09/22, 05/23/22, and 06/06/22 revealed the	F 684	of Nursing on a weekly basis as part of the quality assurance meeting for compliance. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 6/27/2022 the Director of Nurses and Registered Nurse Supervisor began in-service education to all full time, part time, and as needed and agency nurses, certified nursing assistants, transportation aide, and unit secretary. Topics included: • Weight Management Policy • Following physician orders for weights. • Follow through on orders for weights • How to apply these principles to their daily practice. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance (QA) process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by July 4, 2022. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:	

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F 684	Continued From page 77 MAR was blank or charted as "9" because the weight had not been obtained. She stated The Transportation Aide did weights and if the weights had not been done, she had been told (she could not remember by whom) to document "9" on the MAR. During an interview with the Director of Nursing (DON) on 06/08/22 she confirmed she was unable to provide any additional weight documentation for Resident #85. She stated the weight had not been obtained if the MAR was blank or had a "9" charted. The DON stated weights should be obtained as ordered. A follow-up interview with the DON on 06/09/22 at 09:06 AM revealed the nurse assigned to the resident was responsible for notifying the Nurse Aide (NA) the resident needed to be weighed. She stated if the NA was unable to obtain the weight they should notify the nurse and if the nurse was unable to obtain the weight, he or she should notify management. The DON stated a problem with obtaining weights had been identified in the past and different approaches to ensuring the weights were obtained had been utilized, such as having the Transportation Aide assist with weights or changing scheduled days for daily/weekly weights. She stated no concerns were identified with obtaining weights in April 2022 and May 2022. An interview with the Transportation Aide on 06/09/22 at 10:04 AM revealed he tried to help with obtaining weights when he had time. He explained he got a list from the Unit Secretary each week with the names of who needed a daily weight, a weekly weight, or a monthly weight. The Transportation Aide stated he worked on	F 684	On 7/6/2022, The Director of Nursing, and/or designee will utilize the QA tool for Weight Monitoring to monitor compliance with the timely and accurately obtaining weights as ordered. The Director of Nurses, and/or designee will monitor 5 residents with orders for weekly weights weekly for 4 weeks, then monthly for 2 months to ensure weights obtained as ordered. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director. Date of Compliance: 7/4/2022	

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obtaining weights when he wasn't doing transports. He stated if he was not able to obtain the weights on the list he notified the Unit Secretary and she notified management. The Transportation Aide said there were quite a few times he was unable to obtain weights due to having transports scheduled.

An interview with the Unit Secretary on 06/09/22 at 10:17 AM revealed she gave the Transportation Aide a list of weights once a week of who needed a daily, weekly, or monthly weight. She stated he notified her if he was unable to complete the weights and then she notified the DON of who was not weighed.

An interview with the Physician on 06/09/22 at 12:28 PM revealed he expected weights to be obtained as ordered.

An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected weights to be obtained as ordered.

b. Review of Resident #85's Physician orders revealed an order for compression stockings to be applied in the morning and removed at bedtime dated 09/03/21.

Review of the quarterly Minimum Data Set (MDS) dated 05/09/22 revealed Resident #85 was severely cognitively impaired and received a diuretic 7 out of 7 days during the look back period.

An observation of Resident #85 on 06/06/22 at 11:41 AM revealed she was sitting in her wheelchair and no compression stockings were in place. Edema was noted to both lower legs and

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feet.

An observation of Resident #85 on 06/07/22 at 10:45 AM revealed she was lying in bed and no compression stockings were in place.

An observation of Resident #85 on 06/07/22 at 01:16 PM revealed she was sitting in her wheelchair and no compression stockings were in place. Edema was noted to both lower legs and feet.

An observation of Resident #85 on 06/08/22 at 02:12 PM revealed she was sitting in her wheelchair and no compression stockings were in place. Edema was noted to both lower legs and feet.

Review of Resident #85's June 2022 Medication Administration Record (MAR) revealed her compression stockings were charted as being in place as ordered on 06/06/22, 06/07/22, and 06/08/22.

An interview with Nurse #5 on 06/08/22 at 04:02 PM confirmed she cared for Resident #85 on 06/06/22, 06/07/22, and 06/08/22. Nurse #5 stated she did not personally apply Resident #85's compression hose on 06/06/22, 06/07/22, and 06/08/22 and she did not know if Resident #85 had compression stockings in place or not.

An interview with the Director of Nursing (DON) on 06/08/22 at 04:35 PM revealed she expected nurses to follow Physician orders, and if a resident had an order for compression stockings they should be in place as ordered.

An interview with the Physician on 06/09/22 at

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F 684	Continued From page 80 12:28 PM revealed he expected compression stockings to be in place as ordered. He stated if there was an issue that the resident would not wear the compression stockings, did not like the compression stockings, or any other reason the compression stockings were not being worn he would like to be notified so the order could be discontinued if appropriate. An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected compression stockings to be in place as ordered by the Physician, or there should be a nurse's note stating why the compression stockings were not in place.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete weekly skin assessments for 1 of 5 residents reviewed for pressure ulcers (Resident #71).	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	7/4/22

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F 686	Continued From page 81 The findings included: Resident #71 was admitted to the facility on 08/20/19 with diagnoses including dementia. Review of the Wound Care Nurse Practitioner (NP) progress notes for Resident #71 revealed treatments were in place for a facility acquired stage 2 pressure ulcer located on the right buttock. The Wound Care NP treatments for the ulcer started on 02/04/22. The comprehensive care plan identified a current pressure ulcer to the buttock and risk for development of additional pressure ulcers due to the decreased ability to reposition, incontinence, and a history of ulcers. Interventions included weekly full body skin assessments initiated on 02/08/22. The weekly skin assessments revealed none were documented as having been completed for the following weeks: 03/06/22, 04/24/22, 05/01/22, 05/08/22, and 05/22/22. Review of the discharge Minimum Data Set (MDS) dated 04/26/22 assessed Resident #71 as having moderately impaired cognition and needing extensive assistance with bed mobility, transfers, and toilet use. The MDS documentation identified two facility acquired pressure ulcers, one stage 2 and one stage 3.	F 686	compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer Corrective action for resident(s) affected by the alleged deficient practice: On 6/9/2022, the Director of Nursing assessed resident #71 skin and notified MD and initiated and implemented weekly skin checks for monitoring of skin breakdown. No skin breakdown noted. Corrective action for residents with the potential to be affected by the deficient practice: All residents who are at risk for skin breakdown have potential to be affected by the alleged deficient practice. On 6/29/2022, the Director of Nursing and Unit Managers reviewed 100 % of current resident records to ensure weekly skin checks initiated and being completed. Body audit was completed for any resident identified as not having weekly skin check. Systemic Changes: On 6/29/2022, the Director of Nursing	

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F 686	Continued From page 82 An interview was conducted on 06/10/22 at 4:39 PM with Nurse #2 who's assignment today included Resident #71. Nurse #2 revealed she usually was scheduled to complete two or three skin assessments for residents on the days she worked and was able to complete the ones she was responsible for. Nurse #2 revealed the nurses were responsible for their assigned skin assessments and didn't know why it wasn't consecutively done for Resident #71. During an interview on 06/10/22 at 5:27 PM the Director of Nursing (DON) confirmed every resident was scheduled to have a weekly skin check. The DON revealed it was her expectation the nurses complete the weekly skin checks on their assignment and should have been done for Resident #71.	F 686	began educating all full time, part time, and prn nurses, medication aides, and nurse aides and agency staff on the following topics: • Wound Prevention and Weekly Skin Monitoring Process Any clinical staff (full time, part time, PRN, and agency) who did not receive in-service training by 7/4/2022 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation. Quality Assurance: On 7/6/2022, The Director of Nurses or designee will monitor Compliance using the QA Tool for Pressure Ulcer Prevention. Monitoring will include observation at least 5 residents to ensure weekly skin checks are completed. This is to be completed 5 x a week for 2 weeks, then weekly x 2 weeks, then monthly x 2 months. Reports will be presented by the Director of Nursing to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary	

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F 686	Continued From page 83	F 686	Manager. Date of Compliance: 7/4/2022	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, and Physician interviews the facility failed to follow the standing order for the use of supplemental oxygen for 1 of 1 resident reviewed for respiratory care (Resident #16). Findings included: Resident #16 was admitted to the facility 08/13/21 with diagnoses including asthma and chronic obstructive pulmonary disease (abbreviated as COPD and meaning a condition involving constriction of the airways and difficulty breathing). Resident #16 had a Physician order dated 08/13/21 to follow facility standing orders. The facility's standing order for supplemental oxygen use reads as, "for shortness of breath or oxygen saturation (the amount of oxygen in the	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 Respiratory/Tracheostomy Care and Suctioning Corrective action for resident(s) affected by the alleged deficient practice: For resident #16, the oxygen orders were confirmed with the physician by the	7/4/22

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F 695	Continued From page 84 blood) less than 90% on room air, elevate the head of the bed, document oxygen saturation, and start oxygen. Increase oxygen until oxygen saturation is greater then or equal to 90%. Do not exceed 4 liters per minute. Call Physician. If not in distress wait until office hours with vital signs, oxygen saturation, and assessment. Write an order if oxygen is to continue". Review of Resident #16's Physician orders revealed no order for oxygen use. The quarterly Minimum Data Set (MDS) dated 03/08/22 revealed Resident #16 was cognitively intact and used oxygen. Review of the respiratory care plan last updated 06/08/22 revealed Resident #16 had COPD. Interventions included monitoring for signs or symptoms of acute respiratory insufficiency including anxiety, confusion, and restlessness; and administering oxygen therapy as ordered by the Physician. An observation of Resident #16 on 06/06/22 at 10:39 AM revealed she had oxygen in place at 3 liters per minute via nasal cannula (a tube in the nose). An interview with Resident #16 on 06/06/22 at 10:39 AM revealed she usually wore oxygen continually and thought she was to receive oxygen at 2 liters per minute. She stated she was not sure how long she had been using oxygen in the facility. An observation of Resident #16 on 06/07/22 at 10:44 AM revealed she had oxygen in place at 4 liters per minute via nasal cannula.	F 695	Assistance Director of Nursing on 06/9/2022 and state that oxygen is to be provided at 3 liters per minute continuously via nasal cannula. On observation by the Assistant Director of Nurse on 06/9/2022 and the O2 flow rate was confirmed to be set at 3 l pm and the oxygen delivery in place as ordered. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 6/29/2022, the Assistant Director of Nursing audited all current residents receiving oxygen. Oxygen flow rate was observed for compliance and orders for oxygen confirmed with the physician to assure there were no conflicting oxygen orders in place. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/27/2022, the Director of Nurse/Assistant Director of Nurses and Nurse Consultant began education to all full time, part time, and PRN Nurses and agency nurses on the following: • Resident's liter flow of oxygen must be set at the amount ordered by the MD and the order confirmed by the nurse. • The liter amount should be verified at eye level. • If the resident is adjusting the oxygen liters, then their respiratory status should be assessed or if refusing to utilize the oxygen notify the MD/RP of your findings. • Oxygen orders should be clarified to	

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F 695	Continued From page 85 An observation of Resident #16 on 06/07/22 at 01:41PM revealed she had oxygen in place at 4 liters per minute via nasal cannula. An observation of Resident #16 on 06/08/22 at 08:56 AM revealed she had oxygen in place at 4 liters per minute via nasal cannula. The nurse caring for Resident #16 on 06/06/22, 06/07/22, and 06/08/22 was unavailable for interview during the investigation. An interview with the Physician on 06/09/22 at 12:57 PM revealed nursing should have obtained an order for oxygen use when oxygen was applied. He stated Resident #16 also needed to be monitored after the supplemental oxygen was applied by checking her oxygen saturation to see if the oxygen was effective for her. An interview with the Director of Nursing (DON) on 06/09/22 at 05:01 PM revealed Resident #16 should have had an order for oxygen when it was applied. An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected nursing to obtain a Physician order when placing residents on oxygen.	F 695	assure there are no conflicting orders in place. • Documentation of notification and education should be completed in the progress notes for the resident along with the resident's condition. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by July 4, 2022. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses or designee will begin monitor compliance on 7/6/22 utilizing the F695 Quality Assurance Tool - compliance with oxygen liter flow according to MD orders for 5 residents, weekly x 4 weeks then monthly x 2 months or until resolved. The Director of Nursing will Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as	

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F 695	Continued From page 86	F 695	appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 07/04/2022	
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		7/4/22

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F 725	Continued From page 87 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to maintain sufficient nursing staff to ensure a resident (Resident #84) was not left lying in a soiled brief while waiting for staff to respond to an engaged call light for incontinence care. The facility failed to ensure requests from a resident dependent on staff for transfer (Resident #87) was not left in bed after multiple requests to get out of bed. The facility failed to ensure residents dependent on staff to provide physical assistance with bathing received showers as scheduled (Resident #18, 28, 38, 46, 47, 84, 85, 87). As a result of these failures residents expressed feeling dirty, mad, isolated, and forgotten about. These failures affected 8 of 17 residents sampled in the areas of dignity, choices, and activities of daily living. The findings included: This tag is cross referenced to: 1. F 550: Based on record review, observations, resident and staff interviews, the facility failed to maintain residents' dignity when there was a delay in answering their call light when toileting/incontinence care was needed, not providing showers/bathing assistance as scheduled and not providing assistance out of bed when requested resulting in residents feeling "dirty, mad, isolated and forgotten about." This affected 3 of 14 sampled residents (Residents #46, #84 and #87) reviewed for activities of daily living and dignity.	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F725 SUFFICIENT STAFFING Corrective action for affected residents: For resident # 84: On 6/9/22 Incontinent care provided by assigned certified nursing aide (CNA). For resident□s #87: On 6/9/22 assigned CNA assisted resident with getting dressed and out of bed and up to wheelchair prior to activities. For resident #18, #28, #38, #46, #47, #84, #85, and #87: On 6/9/22 assigned certified nursing aide (C NA) completed bed baths. Corrective action for potentially affected residents: On 6/10/2021, a 100% review of staffing ratios and assignments were completed by the Director of Nursing, Administrator,	

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F 725	Continued From page 88 2. F 561: Based on record review, observations, resident and staff interviews, the facility failed to provide residents with their preferred method of bathing and number of showers per week (Residents #47, #38, #28, and #18) and failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #87) for 4 of 15 residents reviewed for choices and Activities of Daily Living (ADL). 3. F 677: Based on observations, record review, resident and staff interviews, the facility failed to provide showers or bed baths as scheduled for 4 of 13 sampled residents (Residents #46, #84, #87, and #85) reviewed for Activities of Daily Living (ADL). An interview with the Director of Nursing (DON) on 06/07/22 at 2:55 PM revealed she reviewed the nursing schedule and tried to ensure 6 to 7 Nurse Aide (NA) staff were assigned for day and evening shifts and 4 to 6 assigned for night shift. The DON revealed there were times staffing goals were not met. During an interview on 06/08/22 at 9:20 AM the Scheduler revealed she was responsible for creating the nursing staff schedule. On 06/08/22 there were five Nurse Aides (NA), a Medication Aide, and four Nurses scheduled for day shift. Each NA was assigned approximately 22 residents to provide care. The Scheduler revealed she did not use a staffing agency to cover shifts and if there were callouts, she would ask someone already working to stay over, call other staff, or stay herself until the shift was covered.	F 725	and Nurse Management team. The review revealed sufficient staffing for the facility based on ratios and acuity. Nursing scheduler notifies the Director of Nursing if staffing levels are below the desired ratios. The Director of Nursing coordinates the call out plan which includes staff members from previous shift providing ongoing coverage until coverage is found. Systemic changes: On 6/7/2022, facility hired two additional supportive care aides (1 for day shift and 1 for evening shift) to assist with answering call lights, passing meal trays, and providing feeding assistance. On 6/22/2022, Facility initiated virtual hiring forum on Indeed to aid in increasing staffing. Facility posted fliers for Nurse Aide positions throughout the community and began advertising on social media platforms. On 6/22/2022, facility began limiting admissions and monitored daily census to ensure accurate staffing ratios based on resident acuity. Facility reviewed staffing needs with three agency contracts. Orientation for new hires is offered on a weekly basis. On 6/27/2022, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: " The importance of staff call-outs,	

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F 725	Continued From page 89 An interview was conducted on 06/10/22 at 5:34 PM with the Administrator. The Administrator revealed the facility had experienced a high turnover in nursing staff. They had used two agencies to help but hadn't had good response with agency staff showing up. The Administrator revealed she was aware there were issues with residents getting their scheduled showers and a delay with call light response times. To help with staffing issues the Administrator indicated the resident census and number of staff were considered and new admissions were either passed or deferred for a couple days and eleven residents were discharging from the facility this week. The Administrator revealed the facility also implemented a retention program and gave a $500 bonus if staff met criteria. Wage adjustments were also made and just got approval for another pay increase. The Administrator revealed she had spoken with staff about communication when they were unable to provide showers and the role they play in group assignments including recruiting new staff, and in providing ideas to help with staffing issues. The Administrator revealed admissions were stopped for a short period of time or postponed until staffing stabilized but new resident admissions hadn't stopped for any significant length of time.	F 725	notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically ADL care. " The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL needs of the residents. " Providing timely ADL care " Resident Preferences related to showers " Call Light Response Times The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 7/4/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance: On 7/6/22 The Director of Nursing or the Administrator will monitor this issue using the Survey Quality Assurance Tool for Sufficient Staffing. The review will consist	

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F 725	Continued From page 90	F 725	of at reviewing staffing ratios and assignments at least 3 x weekly x 4 weeks, then weekly x 2 months or until resolved by the Quality of life/Quality Assurance Committee; a review of staffing schedules, staffing ratios, and assignments to include resident acuity, and reviewing for any grievance reports related to staffing. Interventions will be implemented as appropriate. Reports will be presented by the Administrator in the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 7/4/2022	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide adaptive equipment for 1 of 2 residents who was determined to need a maroon spoon (a spoon with a shallow bowl that limits the amount of food	F 810	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	7/4/22

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F 810	Continued From page 91 placed on the spoon) reviewed for adaptive equipment (Resident #11). Findings included: Resident #11 was admitted to the facility 04/27/11 with a diagnosis of dysphagia (difficulty swallowing). Review of Physician orders revealed an order dated 11/27/19 for Resident #11 to receive a puree diet (food that is cooked to a paste consistency) with thin liquids and a maroon spoon. A quarterly Minimum Data Set (MDS) dated 05/13/22 revealed Resident #11 was severely cognitively impaired, required supervision assistance with eating, had no weight loss, and received a mechanically altered diet. The care plan for nutrition last updated 06/02/22 revealed Resident #11 received a mechanically altered diet and interventions included reminding her to take her time eating and providing a maroon spoon with meals. An observation of Resident #11's lunch meal tray on 06/06/22 at 01:31 PM revealed a prepacked sleeve of plasticware was on the resident's tray and contained a spoon, a knife, and a fork. An observation of Resident #11's meal ticket at the same date and time revealed she was to receive a maroon spoon. No maroon spoon was observed to be on Resident #11's meal tray. An observation of Resident #11 on 06/06/22 at 01:32 PM revealed she was feeding herself with a regular plastic spoon and was taking bites so	F 810	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F810 Assistive Devices- Eating Equipment/Utensils Corrective action for resident(s) affected by the alleged deficient practice: Maroon spoons were immediately provided for Resident #11 on 6/7/22 by nurse aide. Speech Therapy (ST) verified that this was a current recommendation for resident #11. Interdisciplinary Team reviewed resident #11 and there was no weight loss/change in conditions observed. On 6/9/2022, The Administrator verbally in-serviced Dietary Manager, Cooks, Dietary Aides, MDS, Rehab, certified nursing aides (C.NA)s and licensed nurses regarding .appropriate adaptive equipment is placed on meal tray for residents. Corrective action for residents with the potential to be affected by the alleged deficient practice: All current residents who require adaptive equipment for meals have the potential to be affected by the alleged deficient practice. On 6/7/22, the Administrator completed audit of all resident with order	

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F 810	Continued From page 92 large the food was hanging off the spoon. During an interview with Activity Assistant #1 on 06/06/22 at 01:33 PM she confirmed she set-up Resident #11's lunch meal tray and there was no maroon spoon on Resident #11's tray. She stated she did not notice Resident #11's meal ticket stated she was to receive a maroon spoon. During the interview Activity Assistant #1 called the kitchen to ask about the maroon spoon for Resident #11's meal tray and was told by a dietary staff member the kitchen did not have any maroon spoons to send to the hall. An interview with Dietary Aide #1 on 06/07/22 at 08:52 AM revealed she was the dietary staff member responsible for checking meal trays for accuracy before they left the kitchen for the lunch meal on 06/06/22. She stated she knew Resident #11 should have received a maroon spoon on her tray but there were no maroon spoons to send. Dietary Aide #1 stated she did not notify the Assistant Dietary Manager that there was no maroon spoon to send on Resident #11's meal tray. An interview with the Assistant Dietary Manager on 06/07/22 at 09:04 AM revealed she was acting as the Dietary Manager until a permanent Dietary Manager was hired. She explained the dietary aide at the beginning of the tray line put adaptive equipment on the meal tray and sent the tray to the dietary aide at the end of the line. The Assistant Dietary Manager stated the dietary aide at the end of the line checked the tray for accuracy and loaded it onto the meal cart. She stated it was a frequent problem that maroon spoons got thrown away but the kitchen did have maroon spoons available on 06/06/22 for the	F 810	for adaptive equipment. Observation rounding was by Administrator to ensure adaptive equipment placed on meal tray. On 6/8/22 Asst. Dietary Director completed an audit of the train line process to ensure all adaptive equipment was being sent out as ordered. No other residents identified as not having adaptive equipment on meal tray. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Dietary Manager, Cooks and Dietary Aides were in-serviced using the policy and procedure on meal tray preparation on 6/30/2022 by the Administrator. Staff Signatures were collected to ensure staff acknowledgment utilizing policy and procedure. Any dietary staff not in serviced by 7/4/2022 will not be allowed to work until education completed. Any Newly Hired staff will be educated policy and procedure on meal tray preparation during orientation and will not be permitted to work until it has been completed. Quality Assurance: On 7/6/2022, the Administrator will begin monitoring using the F810 QA Tool to ensure residents have the appropriate adaptive equipment. This audit will be completed on a sample of 5 resident for a variety of meals, weekly x4 then monthly x 2. QA to ensure compliance and identify areas of improvement as needed. Reports will be presented to the weekly Quality	

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F 810	Continued From page 93 lunch meal and she felt it was not placed on Resident #11's meal tray because prepackaged utensils were used and the maroon spoon was overlooked. The Assistant Dietary Manager stated if adaptive meal equipment was ordered for a resident the resident should receive the adaptive equipment. During an interview with the Speech Therapist (ST) on 06/08/22 at 09:12 AM she confirmed the recommendation for Resident #11 to receive a maroon spoon on her meal tray came from the speech therapy department and was still an active order. She stated the maroon spoon was important for Resident #11 because she took very large consecutive bites and it gave her the independence to feed herself but decreased the amount of food she was able to put in her mouth at a time. The ST stated because the maroon spoon cut down on the amount of food Resident #11 was able to put in her mouth it decreased the risk of choking. She stated residents with orders for adaptive meal equipment should receive the equipment on their meal trays. An interview with the Director of Nursing (DON) on 06/09/22 at 05:01 PM revealed she expected residents to receive adaptive equipment on their meal tray as ordered. An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected residents to receive adaptive equipment on their meal tray as ordered.	F 810	Assurance (QA) committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager. Date of Compliance: 7/4/2022	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		7/4/22

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F 812	Continued From page 94 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure kitchen equipment was kept clean by not removing a buildup of debris from 1 of 2 ice machines (kitchen ice machine). This practice had the potential to affect residents who were served ice from this machine. The findings included: The initial tour of the kitchen was done on 06/06/22 at 9:29 AM with the Assistant Dietary Manager (ADM). An observation of the ice machine revealed a buildup of brownish colored, slime-like debris along the lower part of a plastic ice cube guide where ice was stored inside the machine. The plastic guide directed formed ice cubes into the storage bin of the machine.	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F812- Food Procurement, Store, Prepare, Serve-Sanitary Corrective action for affected resident: Kitchen ice machine guard was cleaned	

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F 812	Continued From page 95 During an observation and interview on 06/06/22 at 9:34 AM the ADM revealed she asked the Dietary Aide to remove the buildup on the ice cube guide observed during initial tour and was easy to remove. An observation of the plastic guide revealed the brown colored buildup was removed but a brown colored stain remained on the plastic guide where the debris had been. The ADM revealed there was no cleaning schedule to show the plastic ice cube guide was regularly cleaned but should be done weekly. The ADM stated she did a walk around in the kitchen to check equipment for cleanliness each week but was unsure the last time she checked the ice machine. The ADM stated the ice cube guide should be cleaned anytime it was noted to have a buildup of debris but was missed. An interview was conducted with the Administrator on 06/10/22 at 5:32 PM. The Administrator stated she would expect the ice machine in the kitchen was kept clean and not have a buildup of debris on the ice guard.	F 812	immediately on 6/6/22 by the assistance dietary director. Corrective Action for Potentially Affected Residents: All current residents have the potential to be affected by the alleged deficient practice. The facility ice machines were audited and it was note that there were 2 ice machines currently functioning and providing ice to residents. On 6/6/22 a review of the facility's second ice machine guard was completed and was cleaned per facility sanitation processes. Systemic Changes: On 6/6/22 cleaning of the ice machine guard was added to the dietary aide weekly task list. On 6/28/22 The Administrator began education with dietary manger and dietary staff on sanitation of the ice machine. Any dietary staff who does receive education by 7/4/2022 will not be allowed to work until education completed. Quality Assurance: On 6/27/2022, Administrator began audit checks on the ice machine and the cleaning audit tool to ensure compliance and education was provided to the dietary staff recording the cleaning of the machines guard . On 7/6/22, The Administrator will monitor ice machines weekly x 4 weeks then monthly x2 months using the Dietary QA	

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F 812	Continued From page 96	F 812	Audit Tool. Monitoring will include auditing all ice machine in facility for cleanliness and buildup of debris. Quality Assurance (QA)Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, Assistant Director of Nursing, Staff Development Coordinator and other members of the interdisciplinary team, attend the monthly QA meeting. Date of Compliance: 7/4/2022	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		7/4/22

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F 842	Continued From page 97 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 98 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain an accurate Medication Administration Record (MAR) for applying compression stockings for 1 of 5 residents reviewed for unnecessary medications (Resident #85). Findings included: Resident #85 was admitted to the facility with diagnoses of hypertension (high blood pressure), diabetes, and renal insufficiency (a condition in which the kidneys do not filter properly). Review of Resident #85's Physician orders revealed an order for compression stockings to be applied in the morning and removed at bedtime dated 09/03/21. Review of the quarterly Minimum Data Set (MDS) dated 05/09/22 revealed Resident #85 was severely cognitively impaired and received diuretics 7 out of 7 days during the look back period. An observation of Resident #85 on 06/06/22 at 11:41 AM revealed she was sitting in her wheelchair and no compression stockings were in place.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 Resident Records- Identifiable Information Corrective action for resident(s) affected by the alleged deficient practice: On 6/8/22 the Assistant Director of Nursing assessed resident #85 then notified the medical provider and with no new orders. Ted hose were applied by the assigned nurse aide. Nurse#5 verbally reeducated related following MD orders. Corrective action for residents with the potential to be affected by the deficient practice:	

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F 842	Continued From page 99 An observation of Resident #85 on 06/07/22 at 10:45 AM revealed she was lying in bed and no compression stockings were in place. An observation of Resident #85 on 06/07/22 at 01:16 PM revealed she was sitting in her wheelchair and no compression stockings were in place. An observation of Resident #85 on 06/08/22 at 02:12 PM revealed she was sitting in her wheelchair and no compression stockings were in place. Review of Resident #85's June 2022 Medication Administration Record (MAR) revealed her compression stockings were charted as being in place as ordered on 06/06/22, 06/07/22, and 06/08/22. An interview with Nurse #5 on 06/08/22 at 04:02 PM confirmed she cared for Resident #85 on 06/06/22, 06/07/22, and 06/08/22. Nurse #5 stated she did not personally apply Resident #85's compression hose on 06/06/22, 06/07/22, and 06/08/22 and she did not know if Resident #85 had compression stockings in place or not. She stated she signed the MAR as the compression stockings being in place out of habit. An interview with the Director of Nursing (DON) on 06/08/22 at 04:35 PM revealed if Resident #85's MAR was initialed as compression stockings being in place, the resident should have been wearing the compression stockings. She stated it was the nurse's responsibility to follow-up and make sure the compression stockings were in place when initialing the MAR.	F 842	On 6/9/2022 the Assistant Director of Nursing completed a 100 % audit of all current residents with orders for ted hose in order to validate that ted hose being applied as ordered. For the seven (7) residents identified with order for ted hose, they were noted with ted hose applied as ordered. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/27/22, the Director of Nursing began educating all full time, part time, and prn nurses, and agency licensed staff on the following topics: • Resident Records- Identifiable Information to include MD orders related to ted hose and accurate documentation. If training is not completed by 7/4/2022, the employee will not be allowed to work until completed. The Director of Nursing will ensure that newly hired nurses and agency nurses who have not completed education by 7/4/2022 will not be allowed to work until it has been completed. Education on Resident Records has been incorporated into new hire and agency orientation. All agency nurses utilized by the facility will receive education on Resident Record related to Plan of Correction prior to working their shift. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:	

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F 842	Continued From page 100 An interview with the Physician on 06/09/22 at 12:28 PM revealed he expected compression stockings to be in place as ordered. He stated if there was an issue that the resident would not wear the compression stockings, did not like the compression stockings, or any other reason the compression stockings were not being worn he would like to be notified so the order could be discontinued if appropriate. An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected compression stockings to be in place if nurses were documenting they were applied as ordered, or there should be a nurse's note stating why the compression stockings were not in place.	F 842	On 7/6/2022, the Director of Nursing or designee will monitor compliance utilizing F-842 Resident Records Quality Assurance (QA) tool. Observation will include observations of 5 residents with TEDS hose and documentation 5 x weekly x 2weeks, then weekly x 2 weeks, then monthly x 2 months. The ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 7/4/2022	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		7/4/22

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 102 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to: 1) establish infection control policies and procedures to reduce the risk of growth and spread of Legionella in the building water systems that could affect 107 of 107 residents, 2) ensure nursing staff followed the facility's infection control policy when Nurse #5 did not don gloves when administering an insulin injection and did not perform hand hygiene after checking a resident's blood glucose (Resident #7 and Resident #101) during medication administration, 3) ensure nursing staff changed gloves and performed hand hygiene after performing incontinence care (Resident # 85) for 1 of 13 sampled residents, and 4) ensure hand hygiene was performed after removing gloves and soiled dressings during wound care (Resident #71 and Resident #79) for 2 of 3 sampled residents. Findings included: 1. Review of the facility's Emergency Preparedness plan revealed no information related to a facility water safety management program to minimize the risk of transmission of Legionella Disease to the residents staff and visitors.	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION CONTROL Corrective action for affected residents: For resident #101- On 6/6/2022 Resident assessed by DON. No acute distress noted. MD notified with no new orders. Nurse #5 verbally reeducated related hand hygiene and glove use. For resident #71- On 6/6/2022 Resident assessed by DON. No acute distress. MD notified with no new orders. Nurse #1 verbally reeducated related to hand hygiene during wound care.	

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F 880	Continued From page 103 In an interview on 6/10/22 at 4:15 PM, The Administrator stated she was unaware of the requirement to develop a program to minimize the risk of transmission of Legionella through the facility's water system. She stated that she spoke with the facility Maintenance Director, and he was also unaware of the requirement. She further revealed the facility water was supplied by the city and no water testing had been completed by the facility. 2. Review of the facility policy entitled "Hand Hygiene" approved on 12/2021 revealed the following statement: "It is the policy of the facility that hand hygiene be regarded as the single most important means of preventing the spread of infections. This policy is developed using the Centers for Disease Control's Guidelines for Hand-Hygiene in Health-Care Settings." Under the Definition section of the policy, hand hygiene was defined as "performing hand washing, antiseptic hand wash, alcohol-based hand rubs, surgical hand hygiene/antisepsis." The policy then listed specific indications for activities that required hand hygiene including after removing gloves and after handling used dressings or other items potentially contaminated with any resident's blood, excretions, or secretions. An observation of Nurse #3 performing wound care for Resident # 79 was completed on 06/08/22 at 11:27 AM. Resident # 79 had a wound on the top of her right foot and a wound on her left heel. Nurse #3 washed her hands with soap and water in the resident's bathroom sink and donned gloves. She then removed the existing dressing from the wound on the top of Resident # 79's foot and cleaned the wound bed	F 880	For resident #79- On 6/8/2022 Resident assessed by DON. No signs or symptoms of infection noted. MD notified of deficient practice. Nurse #3 verbally reeducated related to hand hygiene. For resident #85- On 6/8/2022 Resident assessed by ADON. No harm noted to resident. ADON notified housekeeping to wipe down hard surfaces. NA#3 and NA#4 verbally reeducated by Assistant Director of Nursing (ADON) related hand hygiene. On 6/30/22 Infection Control Policy and Procedure-Water Safety Policy updated by the Corporate Chief Nursing Officer to address identification and treatment for Legionella within the facility water system. Corrective Action for Potentially Affected Residents: All current residents and staff have potential to be affected by deficient infection control practices. On 6/6/22-6/10/22, the Infection Control licensed nurse completed Infection Control Rounds to determine if deficient practices noted related to hand hygiene and glove use during wound care, incontinent care, and while performing injection and blood glucose checks. On 6/30/22 Infection Control Policy and Procedure-Water Safety Policy updated by the Corporate Chief Nursing Officer to address to address identification and	

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F 880	Continued From page 104 with saline. She removed her gloves and without performing hand hygiene, donned a new pair of gloves and applied a new dressing to the wound. She then washed her hands with soap and water and donned clean gloves. Nurse #3 removed the dressing on Resident #79's left heel and cleaned the wound bed with saline. She removed her gloves and without performing hand hygiene, she donned a new pair of gloves. She applied the new dressing to the wound on Resident #79's left heel, removed her gloves and washed her hands with soap and water in the resident's bathroom sink. In an interview with Nurse #3 on 06/08/22 at 1:45 PM, she stated she changed her gloves frequently but should have performed hand hygiene after she removed her gloves between cleaning and applying new dressings to both wounds. In a joint interview on 6/10/22 at 5:20 PM the Director of Nursing and the Administrator indicated the hand hygiene policy should be followed by staff and hand hygiene should be performed when a soiled dressing is removed and when gloves are removed. 3. Review of the facility's policy titled "Hand Hygiene" approved 12/2021 read as follows, "It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infections. This policy is developed using the Centers for Disease Control's Guidelines for Hand Hygiene in Health-Care Settings." Under the Definition section of the policy hand hygiene was defines as "performing hand washing, antiseptic hand wash, alcohol-based hand rub, and surgical hand hygiene/antisepsis." The policy then listed	F 880	treatment for Legionella within the water system. The Director of Nursing (DON) began education with all staff on 6/27/2022 on hand hygiene, glove use, and Legionella water management program as it relates to the emergency preparedness policy. Upon receiving 2567, education was started using provided you tube videos on hand hygiene and Personal Protective Equipment per CDC (Center of Disease Control) education series. Beginning 6/27/2022, the Director of Nursing and Assistant Director of Nursing initiated competency education on hand hygiene glove use, and personal protective equipment for unvaccinated staff. Systemic Changes: On 6/28/2022, a root cause analysis was completed for failure to perform hand hygiene, utilizing proper PPE, and Legionella water management program by the Director of Nursing and findings were shared with the interdisciplinary team. The root cause found for failure to provide hand hygiene after checking blood glucose, after performing incontinent care and after removing gloves and soiled dressing during wound care were due to staffing, lack of knowledge, and lack of supervision and monitoring. On 6/28/2022 The root cause analysis done by the QA Nurse Consultant and the Corporate Chief Nursing Officer, found for failure to provide infection control policies	

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F 880	Continued From page 105 specific indications for hand hygiene including after offering incontinence care. The Other Hand Hygiene Guidelines section of the policy read in part as, "if gloves are worn for a procedure, hand hygiene is to be completed after removal and deposit of gloves in an appropriate container. The use of gloves does not replace hand hygiene". A continuous observation of Nurse Aide (NA) #3 and NA #4 providing Resident #85 with incontinence care and morning care was made on 06/08/22 from 09:33 AM to 09:50 AM. With her gloved hands NA #3 cleaned stool with resident care wipes, rolled a clean brief under Resident #85, discarded the soiled brief in a trash bag, secured the tabs of the brief, rolled Resident #85 over on her side and placed the mechanical lift sling under her, rolled the mechanical lift over to the bed, used the bed control to adjust the head of the bed, attached the sling to the mechanical lift, used the control on the lift to raise Resident #85 off the bed, moved the lift to the resident's wheelchair, lowered Resident #85 into the wheelchair using the lift control, removed the sling from the mechanical lift, pushed the mechanical lift beside the closet, removed Resident #85's sweater and gown, touched multiple dresser drawer handles while looking for deodorant, applied deodorant to the resident, put an undershirt and a dress on Resident #85, picked up a comb and handed it to NA #4, pushed back the privacy curtain, and removed her soiled gloves. NA #3 then opened multiple dresser drawers until she found Resident #85's pony-tail holders and handed a pony-tail holder to NA #4. NA #3 then cleaned her hands with alcohol-based hand rub. NA #3 did not remove her gloves and perform hand hygiene after	F 880	and procedures to reduce the risk of growth and spread of Legionella was lack of knowledge and lack of oversight and understanding related policies and procedure requirements per CDC guidelines. On 6/28/2022 the Director of Nursing/Infection Control Nurse began education with all staff on hand hygiene, glove use, and policies and procedures to reduce the risk of growth and spread of Legionella. On 6/28/2022 the Director of Nursing began skills observation validations of both hand hygiene and glove use all staff and appropriate PPE for unvaccinated staff. On 6/28/2022, the corporate Quality Assurance (QA) nurse consultant completed COVID policy education for the administrator and director of nursing which included hand hygiene, glove use, appropriate PPE, and Water Safety Management policy based on Centers for disease control (CDC) guidelines. On 6/28/22, the Director of Nursing/ADON began in person education using provided you tube video Clean Hands, on hand hygiene per CDC guidelines which included utilizing appropriate PPE to educate 100% of staff. This education will be incorporated into new hire training for all staff. Education for all facility Registered nurses, Licensed practical nurse, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental	

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F 880	Continued From page 106 removing stool during incontinence care and continued to touch other items in Resident #85's room while wearing soiled gloves. NA #3 did not perform hand hygiene after removing soiled gloves and before touching other items in Resident #85's room. During an interview with NA #3 on 06/08/22 at 09:51 AM she confirmed she wore the same gloves after removing stool during incontinence care that she used to touch other items in Resident #85's room and did not immediately perform hand hygiene after removing soiled gloves. She stated she had been trained to remove her gloves and perform hand hygiene after providing incontinence care and before touching other items in the resident's environment. NA #3 stated it was an oversight that she did not remove her soiled gloves and perform hand hygiene after providing incontinence care for Resident #85. An interview with the Director of Nursing (DON) on 06/09/22 at 05:01 PM revealed she expected hand hygiene to be performed after providing incontinence care and before touching other items in the resident's environment. An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected hand hygiene to be performed any time staff went from a dirty task to a clean task. 4. Review of the facility's policy titled "Hand Hygiene" approved 12/2021 read as follows, "It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infections. This policy is developed using the Centers for Disease	F 880	services, maintenance and dietary staff will be completed by 7/4/2022. Quality Assurance: On 7/6/2022 the Director of Nursing or designee will observe and monitor hand hygiene and glove use during wound care, incontinent care, and while performing injection , blood glucose checks, for 2 day shift and 2 evening shift 3 x a week for 4 weeks then monthly x 2 to ensure that proper hand hygiene and glove use is occurring. On 7/6/2022 the Administrator or designee will observe and monitor facility water safety using QA screening tool for F880 Water Safety- Legionella weekly x 4 weeks then monthly x 2 to ensure that facility infection control policy related Legionella is in compliance. Quality Assurance (QA) Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director.	

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Control's Guidelines for Hand Hygiene in Health-Care Settings." Under the Definition section of the policy hand hygiene was defines as "performing hand washing, antiseptic hand wash, alcohol-based hand rub, and surgical hand hygiene/antisepsis." The policy then listed specific indications for hand hygiene including after handling items potentially contaminated with any resident's blood and after removing gloves.

On 06/06/22 at 11:54 AM Nurse #5 was observed with her gloved hands pricking Resident #101's right index finger with a lancet, applying a drop of blood onto a glucometer test strip, wiping Resident #101's right index finger with a gauze pad, obtaining the glucose reading, removing the test strip from the glucometer, discarding the test strip and gauze pad in the trash can, discarding the lancet in the sharps container (a puncture proof box), and removing and discarding her gloves in the trash can. Nurse #5 then began typing on her computer. No hand hygiene was performed after removing gloves and before typing on her computer.

An interview with Nurse #5 on 06/06/22 at 12:04 PM revealed she should have performed hand hygiene after removing her gloves and before typing on the computer. She stated not performing hand hygiene after glove removal was an oversight.

An interview with the Director of Nursing (DON) on 06/06/22 at 01:22 PM revealed she expected nurses to removed soiled gloves and perform hand hygiene after checking a fingerstick blood glucose.

An interview with the Administrator on 06/09/22 at

Date of Compliance: 7/4/2022

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05:28 PM revealed she expected nursing staff to remove soiled gloves and perform hand hygiene either by washing their hands or using alcohol-based hand rub after checking a fingerstick blood glucose.

5. Review of the facility's policy titled "Medication Administration" approved 12/2021 read in part as follows, "for administration of injections always wear gloves".

An observation of Nurse #5 on 06/06/22 at 12:16 PM revealed she cleaned Resident #7's left upper arm with an alcohol swab and administered 12 units of insulin subcutaneously (an injection in the subcutaneous layer of skin) without wearing gloves.

During an interview with Nurse #5 on 06/06/22 at 12:21 PM she confirmed she did not wear gloves when she administered Resident #7's insulin injection. Nurse #5 stated she did not usually wear gloves when she administered insulin.

An interview with the DON on 06/06/22 at 01:22 PM revealed she expected gloves to be worn when administering injectable medication.

An interview with the Administrator on 06/09/22 at 05:28 PM revealed she expected nursing staff to wear gloves administering insulin.

6. Review of the facility policy titled "Hand Hygiene" approved on 12/21 read in part: "It is the policy of the facility that hand hygiene be regarded as the single most important means of preventing the spread of infections. This policy was developed using the Centers for Disease Control's Guidelines for Hand-Hygiene in

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Health-Care Settings." The policy's definitions for hand hygiene included perform hand washing or use an alcohol-based hand rub. The policy also listed specific activities requiring hand hygiene to include after removing gloves, after handling a used dressing or other items potentially contaminated with a resident's blood, excretions, or secretions.

An observation of Resident #71's wound care was made on 06/08/22 at 11:47 AM. Upon entering the room Nurse #1 used the dispenser of alcohol-based hand sanitizer located inside the room to sanitize her hands. Nurse #1 donned a pair of gloves and began to remove tape, an absorbent pad, and gauze packed inside the sacrum wound. The gauze was moderately soaked with a brown colored drainage and an odor was noted coming from the wound. Nurse #1 removed her gloves and without performing hand hygiene donned a pair of gloves and began to clean the wound bed with gauze moistened with a chlorine antiseptic. Nurse #1 discarded the used gauze then removed her gloves and without hand hygiene donned a pair of gloves and begun to pack the sacrum wound bed with gauze moistened with a chlorine antiseptic. Nurse #1 removed her gloves and without performing hand hygiene donned a pair of gloves and begun to cover the sacrum wound with an absorbent pad and secure with tape. When finished with wound care Nurse #1 removed her gloves and performed hand hygiene.

An interview was conducted with Nurse #1 on 06/08/22 at 11:59 AM. Nurse #1 stated she probably should have washed her hands when she changed her gloves. She reported she was

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F 880	Continued From page 110 trained to wash her hands after removing her gloves. Nurse #1 stated she didn't wash her hands and was trying to get the wound care completed and get back to her assigned hall. During an interview on 06/10/22 at 5:27 PM the Director of Nursing stated it was her expectation the nurses perform hand hygiene and don new gloves after removing a soiled dressing.	F 880		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		7/4/22

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F 888	Continued From page 111 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely	F 888		

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documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to,

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PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 888	Continued From page 113 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement their policy for source control for unvaccinated employees when 4 of 4 unvaccinated staff members were observed wearing medical or KN95 face masks instead of N95 masks while working in the facility (Nurse #1, Nurse #2, Nurse Aide #7, and Medical Records #1). The facility was currently in outbreak status but had no active positive cases for COVID-19 among the residents. Findings included: The facility's COVID -19 Staff Vaccination Policy, revised January 2022, read in part, "Generally, anyone coming into the facility to work or provide services may be considered staff. Regardless of clinical responsibility or resident contact, this policy and its procedures apply to the following	F 888	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F888 Covid-19 Vaccination of Facility Staff Corrective action for resident(s) affected by the alleged deficient practice: On 6/10/2022, the Director of Nursing (DON) completed education Covid-19	

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F 888	Continued From page 114 staff who provide any care, treatment, or other services (clinical and non-clinical) for the facility and/or its residents: facility employees, contract or agency staff, licensed practitioners, student, trainees, volunteers, and individuals who directly provide care, treatment, or other services under contract or by other arrangement. Employees that are not fully vaccinated or have been granted exemptions will be expected to follow all of the core principles of infection control. Additionally, they will be expected to do the following: test weekly and wear fit tested N95 masks as universal source control while in all patient care areas." The facility's COVID-19 staff vaccination spreadsheet provided by the Administrator on 06/06/22 was reviewed and noted the facility had 162 employees of which 128 had received all doses of the primary COVID-19 vaccination series and/or recommended booster. In addition, there were 37 employees who were granted exemptions and included Nurse #1, Nurse #2, Nurse Aide (NA) #7, and Medical Records (MR) #1. During an observation and joint interview on 06/10/22 at 11:21 AM, Nurse #1 and MR #1 were observed walking down a resident hall and past a group of residents participating in an afternoon activity. Nurse #1 and MR #1 were both observed wearing goggles and medical facemasks. Nurse #1 and MR #1 both confirmed they had not received any doses of the COVID-19 vaccinations and had both been granted exemptions. Nurse #1 and MR #1 both stated they were not informed of any other precautions they were supposed to take as unvaccinated employees other than getting tested weekly for	F 888	Staff Vaccination Policy for unvaccinated employees (Nurse #1, Nurse #2, NA #7, and MR #1). On 6/10/2022 employees (Nurse #1, Nurse #2, NA #7, and MR #1) were provided with a fit tested N-95 mask. Corrective Action for Potentially Affected Residents: All current residents in the facility have the potential to be affected have the potential to be affected by the alleged deficient practice. On 6/22/2022, the Administrator completed audits for all unvaccinated staff to ensure N-95 mask compliance and acknowledgement of compliance of unvaccinated staff completed. Signed acknowledgement of compliance for all unvaccinated. Any unvaccinated staff will be fit tested for N95 masks during new hire orientation which includes agency staff. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/28/2022,The root cause analysis related the deficient practice of unvaccinated staff not utilizing proper personal protective equipment was due to lack of knowledge, lack of understanding, lack of staffing, perceptions of availability, lack of more comfortable options, lack of oversight and accountability.	

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F 888	Continued From page 115 COVID-19 and wearing goggles even when the facility was not in outbreak status. During an observation and interview on 06/10/22 at 11:21 AM, NA #7 was observed exiting a resident's room and walked to the sink in the dining room/common area of the hall to wash her hands. NA #7 was observed wearing goggles and a KN95 facemask. NA #7 confirmed she had not received any doses of the COVID-19 vaccine and had been granted an exemption. NA #7 stated she was not informed of any other precautions she was supposed to take as an unvaccinated employee other than get tested weekly for COVID-19 and wear goggles even when the facility was not in outbreak status. During an observation and interview on 06/10/22 at 4:43 PM, Nurse #2 was observed wearing goggles and a medical facemask. Nurse #2 confirmed she had not received any doses of the COVID-19 vaccine and had been granted an exemption. NA #2 stated she was not informed of any other precautions she was supposed to take as an unvaccinated employee other than get tested weekly for COVID-19 and wear goggles even when the facility was not in outbreak status. During an interview on 06/10/22 at 12:09 PM, the Administrator stated in addition to facemasks, unvaccinated employees were required to wear goggles at all times when in the facility and continue to be tested for COVID-19 in line with the county transmission rate, even when not in outbreak status. The Administrator explained they were working on a process for all employees to be fit tested for N95 masks and had not yet made it a requirement for unvaccinated employees to wear N95 masks.	F 888	On 6/22/2022, the Director of Nursing began an in-service education to all full time, part time, as needed facility and agency staff on Covid-19 staff vaccination policy , PPE utilization including N95 mask process. The Director of Nursing will ensure that any Nurse who has not received this training by 7/4/2022 will not be allowed to work until the training is completed. Any new staff or agency staff will be in-serviced as part of the facility orientation process. Quality Assurance: On 7/6/2022 the Administrator will monitor this issue using the Quality Assurance Tool for Monitoring Unvaccinated Staff. The monitoring will include reviewing a sample of unvaccinated staff to ensure compliance with Facility Staff Vaccination policy. This will be completed 5 x weekly for 2 weeks then 3 x weekly x 2 weeks, then weekly x 2 months or until resolved to ensure unvaccinated staff are adhering to staff vaccination policy. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, Minimum data set(MDS)Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director. Date of compliance: 7/4/2022	

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