STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 07/11/22 through 07/15/22. The facility was found in compliance with the reguirment CFR 483.73, Emergency Preparedness. Event ID: 8HZL11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted on 07/11/22 thrgouh 07/15/22. There were 20 allegations investigated. 13 were substantiated and resulted in deficiencies. NC00190328, NC00189788, NC00189309, NC00189107, NC00188595, NC00188415, NC00190836, and NC0019072. Event ID# 8HZL11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		8/12/22

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

Electronically Signed | 08/08/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, and staff interview the facility failed to treat a resident in a dignified manner by not responding to a call light and meeting the resident's request which led to the resident's brief and bed being wet with urine requiring an entire bed change. The resident stated this made her feel unwanted, belittled, and uncared for by everyone except her family or 1 of 2 residents reviewed for dignity (Resident #72). The findings included: Resident #72 was readmitted to the facility on 02/12/21 with diagnoses of Guillain Baree syndrome and dementia and was discharged from the facility on 07/09/22.	F 550	F550 Resident Rights/Dignity 1) Resident #72 discharged from the facility on 7-9-2022. 2) On 7-18-22 the Director of Nursing completed an audit via rounding observation of cognitively impaired residents to ensure ADL care needs are being met, including incontinence care and timely call bell response if applicable. No additional concerns identified. 3) Effective 8/12/22, the Staff Development Coordinator (SDC)/Designee completed education with current facility and agency staff on resident right to receive ADL care to	

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F 550	Continued From page 2 Review of the quarterly Minimum Data Set (MDS) dated 06/17/22 revealed Resident #72 was cognitively intact and required extensive assistance of one staff member for toileting and was always incontinent of bladder. Review of the facility daily assignment sheet for 07/09/22 for 3:00 PM to 11:00 PM revealed that Nurse Aide (NA) #3, NA #10, and NA #11 were assigned on the unit where Resident #72 resided. An interview was conducted with Resident #72's family member on 07/11/22 at 1:58 PM who stated on 07/09/22 she received a video call from Resident #72 at 9:08 PM. She stated that Resident #72's call light was on, and she needed to be changed. She stated that Resident #72 stated that she had turned the call light about 20 minutes prior to calling the family member and had reported that the last time she had received incontinent care was at 1:30 PM. The family member stated that while on the video call with Resident #72 a staff member who she could not recall their name came in and when Resident #72 stated she needed to be changed the staff member stated that she was not assigned to Resident #72 that shift and then exited the room. The family member stated that about 10 minutes later another staff member came into the room to provide incontinent care but by that time Resident #72, her brief, and bed were all wet and needed to be changed. Resident #72 was interviewed via video call on 07/11/22 at 2:25 PM and stated on 07/09/22 she had remained in bed all day. She stated that the staff had woken her up at 5:30 AM to provide incontinent care and then again at 1:30 PM.	F 550	maintain dignity and respect. Education included responsibility of all direct-care nursing staff answering call lights in a timely manner and providing ADL care to meet resident needs per plan of care and as requested. The licensed nurse and/or nurse aide assigned to resident are responsible for completing routine rounds throughout their shift to ensure ADL care needs are met. All direct-care staff should respond to call lights and provide care as requested regardless of room assignments. Newly hired facility and agency staff will receive education during orientation and prior to first shift worked. 4) The Director of Nursing (DON)/Designee will monitor 5 residents for dignity via questionnaire (cognitively intact) and/or observation (cognitively impaired) of ADL care needs, including incontinence care and timely call bell response. Monitoring will be completed three (3) times weekly for four (4) weeks then, weekly for four (4) weeks. The DON will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with resident rights. Completion Date: 8/12/22	

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F 550	Continued From page 3	F 550		

Resident #72 stated that she did not see the staff again until around 9:15 PM when a staff member came in to answer her call light that had been a while but when she told the staff member, she needed to be changed the staff member stated that she was not assigned to take care of Resident #72 that shift and then left the room. Resident #72 stated that about 10 minutes later a new staff member came in to provide incontinent care to her. She stated by that time she was wet and so was her bed and everything had to be changed which made her feel unwanted and uncared for except for her family. Resident #72 stated that it was quite belittling for the staff to have to change not only her but her entire bed as well.

NA #4 was interviewed on 07/11/22 at 5:57 PM and confirmed that she had cared for Resident #72 on first shift (7:00 AM to 3:00 PM) on 07/09/22. She stated that when she arrived for her shift, she checked Resident #72 who was dry and then she checked her again around 11:00 AM and she was still dry. NA #4 stated that she provided incontinent care to Resident #72 around 1:30 PM before she left for the day. She added she was slightly wet, but her bed was dry so, she only had to change her brief.

Nurse Aide (NA) #3 was interviewed on 07/12/22 at 2:33 PM and reported she was working on 07/09/22 from 3:00 PM to 11:00 PM and had answered Resident #72 ' s call light because her assigned NA was on break. NA #3 state that she answered the call light at approximately 9:30 PM and was not sure who was assigned to care for Resident #72 because that was her first day in the facility in 2 years. NA #3 stated that when she answered her call light Resident #72 was on the

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F 550	Continued From page 4 phone with her family member and was wet and needed to be changed. She stated that her bed was also wet and needed to be changed, they were not saturated "but I did not want to leave them soiled." NA #3 did not know which staff member had previously answer Resident #72's call light or how long the call light had been on. NA #10 was interviewed on 07/13/22 at 11:02 AM and confirmed that she worked 07/09/22 from 3:00 PM to 11:00 PM on the unit where Resident #72 resided but stated she did not provide any care to her. She stated she answered her call light around dinner time, and she wanted a cup of ice and that was given to her, she did not mention needing incontinent care at that time. NA #11 was interviewed on 07/13/22 at 1:19 PM and confirmed she worked on 07/09/22from 3:00 PM to 11:00 PM on the unit where Resident #72 resided. She stated she was assigned to sit with another resident on that unit and did not provide any care to Resident #72 during that shift. The Regional Nurse Consultant was interviewed on 07/15/22 at 1:18 PM. She stated that the facility staff were to round on each resident before and after meals, at bedtime and as needed. She stated that Resident #72 should have been checked before and after her evening meal and again at bedtime and if her call light was on then as requested.	F 550		
F 561 SS=G	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	F 561		8/12/22

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F 561	Continued From page 5 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the 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 observations, record review, resident, and staff interview the facility failed to honor a resident choice to have two showers a week (Resident #131) and failed to keep a resident's wheelchair beside his bed per his choice (Resident #47) for 2 of 3 resident reviewed for choices. The findings included: 1. Resident #131 was admitted to the facility on 07/05/22 with diagnoses that included chronic	F 561	F561 Self-Determination 1) Resident # 131 continued to receive showers twice weekly as requested until she discharged on 8-2-2022. Resident #47 continues to have wheelchair accessible at bedside. Shower schedule and care plans updated accordingly. 2) On 7-18-2022 the Director of Nursing completed an audit of cognitively intact residents preference for bathing type and frequency. Cognitively impaired	

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F 561	Continued From page 6 obstructive pulmonary disease. Review of Social Service assessment dated 07/08/22 revealed Resident #131 was cognitively intact. Review of the facility's shower schedule revealed Resident #131 was scheduled for showers on Wednesday and Friday on first shift. Review of Resident #131's documentation report for bathing dated July 2022 indicated that on first shift on Wednesday 07/06/22 Nurse Aide (NA) #4 documented a partial but did not specify if it was a bed bath or shower and on Friday 07/08/22 NA #5 documented a bed bath. An observation and interview were conducted with Resident #131 on 07/11/22 at 10:28 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was standing up in spots and appeared almost wet with oil and the bottom of her feet were black with dirt. She stated that her showers were scheduled for Wednesday and Friday morning, but she had not had a shower since she admitted on 07/05/22. She stated she asked a staff member this morning for a shower, and they told her it was not her shower day, but she did not know who the staff member was. Resident #131 stated she had an appointment on Friday, and she wanted to be sure she had a shower before her appointment. An observation and interview were conducted with Resident #131 on 07/12/22 at 11:08 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was standing up in spots and appeared almost wet with oil and the bottom of her feet were black with	F 561	residents□ representative contacted for preferences. An audit of residents with ambulation devices was completed to ensure devices are easily accessible as appropriate. 3) Effective 8/12/22, the Staff Development Coordinator (SDC) completed education with current facility and agency direct care nursing staff on honoring resident rights related to bathing preferences and accessibility of ambulation devices. Resident bathing preferences and ambulation devices needs will be assessed and care plan updated upon admission, quarterly and with changes to ensure residents are bathed as desired and have access to ambulation devices. Education included the process of the nurse aide notifying the nurse supervisor when a shower is not completed and providing assistance when needed. Newly hired facility and agency direct care nursing staff will receive education upon hire and prior to first shift worked. Point-of-Care (POC) bathing reports will be reviewed during morning clinical meetings for oversight and department heads will monitor accessibility of ambulation devices during daily rounds. 4) The DON/Designee will monitor five (5) residents for bathing preferences and ambulation device accessibility. Monitoring will be completed at a frequency of three (3) X weekly for four (4) weeks then, once weekly for eight (8) weeks. The DON will present the results	

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dirt. She again stated she had asked for a shower yesterday and did not get it.

NA #5 was interviewed on 07/13/22 at 7:59 AM and confirmed that she cared for Resident #131 on Wednesday 07/06/22. She stated that Resident #131 had just admitted to the facility the day before and she did not have any clothes with her. She stated she set her up with a wash basin and wash cloth so she could wash her face. NA #5 stated that Resident #131 did not have a shower that day, but she did not know why, she stated "maybe there was a shower team or maybe she had not been added to the shower sheet yet" but again did not know why Resident #131 did not have a shower that day. NA #5 stated that their assignment sheet indicated who was scheduled for a shower that day and if there was no shower team then the NAs on the hall were responsible for completing the scheduled showers.

NA #4 was interviewed on 07/13/22 at 10:28 AM and confirmed that she cared for Resident #131 for the first time on Friday 07/08/22. NA #4 stated that she did not give Resident #131 a shower on Friday 07/08/22 and she was not sure if there was a shower team or not. She stated that recently they have "been lucky" and had a shower team often but did not recall if they had one on 07/08/22. NA #4 stated that there was a paper at the nurse's station that told them who was scheduled for a shower each day, but she could not recall why Resident #131 did not get one on 07/08/22.

NA #1 was interviewed on 07/14/22 at 2:04 PM who confirmed that she cared for Resident #131 on 07/11/22 and 07/12/22. She stated that on

of monitoring to the QAPI Committee monthly and changes to the plan will be made as necessary to maintain compliance with resident rights to self-determination.

Completion Date: 8/12/22

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07/11/22 Resident #131 did ask for a shower but it was not her scheduled shower day and was told her that her scheduled shower day was on Wednesday, and she seemed ok with that.

The Director of Nursing (DON) was interviewed on 07/15/22 at 12:41 PM. The DON stated that showers were scheduled based upon room or by resident preference and should be given as scheduled. If the resident requested a shower on a non-scheduled shower day, then it should be given by the staff as requested by the resident.

2. Resident #47 was readmitted to the facility on 12/03/21 with diagnoses that included difficulty in walking.

Review of the quarterly Minimum Data Set (MDS) dated 05/04/22 revealed that Resident #47 was moderately cognitively impaired and required one person assistance with transfers. The MDS further indicated that Resident #47 had no falls since the previous assessment.

Review of Resident #47's care plan revealed no care plan intervention to keep his wheelchair in the bathroom or out of his reach.

An observation and interview were conducted with Resident #47 on 07/11/22 at 12:31 PM. Resident #47 was sitting on the side of the bed. He stated that his wheelchair was in the bathroom because he had fallen a while ago and the staff kept it in the bathroom "away from me." Resident #47 stated he could get from his bed to his wheelchair, but they kept his chair in the bathroom and I have to use my call bell but sometimes it takes an hour for anyone to help me. He stated he would like the wheelchair

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beside his bed so he can get to it when he wanted too.

An observation of Resident #47 was made on 07/13/22 at 7:55 AM. Resident #47 was resting in bed with his bedside table next to him. His wheelchair was not beside his bed it was in the bathroom in his room.

Nurse Aide (NA) #6 was interviewed on 07/13/22 at 8:58 AM who confirmed she was familiar with Resident #47. She stated that they kept his wheelchair in the bathroom because he was a fall risk and would try to get up in it, so we place the wheelchair in the bathroom.

NA #7 was interviewed on 07/13/22 at 8:59 AM who confirmed she was familiar with Resident #47. She stated that his wheelchair was kept in his bathroom because he was a fall risk and for space. NA #7 stated that in the past Resident #7 had fallen so we put his wheelchair in the bathroom for safety.

NA #4 was interviewed on 07/13/22 at 10:37 AM. NA #4 stated that Resident #47 can get up to his wheelchair whenever he wanted to, but we must assist him. She stated that they kept his wheelchair in the bathroom to keep him from falling.

Nurse #15 was interviewed on 07/13/22 at 3:48 PM. Nurse #15 stated that if Resident #47 was moving around in the bed she would get him up to his wheelchair. She stated a month or so ago Resident #47 got up and walked out to the hallway and fell. Nurse #15 stated she was unaware of why his wheelchair was kept in the bathroom because Resident #47 could get from

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F 561	Continued From page 10 his bed to wheelchair and vice versa. Nurse #15 stated she kept Resident #47's bed in low position and again if he was up on the side of bed, she would aide him into his wheelchair so he could roll around for bit then he would be ready to go back to bed. NA #8 was interviewed on 07/14/22 at 3:06 PM. She stated that she gave Resident #37 a shower today and he transferred very easily and could get into his wheelchair if it was kept beside his bed. She added he was able to get into the shower chair with stand by assistance. An observation and interview with Resident #47 were conducted on 07/14/22 at 3:08 PM. Resident #47 was sitting on the side of the bed and again stated that he wanted his wheelchair, but it was in the bathroom, and he could not walk over there to get it. He stated, "I want it here by my bed." Nurse #2 was interviewed on 07/14/22 at 3:13 PM who stated that they try to keep Resident #47 away from his wheelchair because he tires to get in it, and I she thought he had fallen in the past, so we keep his chair out of reach. The Director of Nursing (DON) was interviewed on 07/15/22 at 2:05 PM. The DON stated that Resident #47 should be able to have his wheelchair at beside per his choice.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family	F 565		8/12/22

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F 565	Continued From page 11 group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident Council Meeting Minutes, resident and staff interviews, the facility failed to resolve dietary grievances that were reported in the Resident Council meetings (1/14/2022, 1/17/2022, 3/10/2022, and 3/31/2022).	F 565	F565- Resident/Family Group and Response 1. Dietary Grievances reported in Resident Council Meetings on 1/14/22, 1/17/22, 3/10/22, and 3/31 were addressed by 8-8-2022. The Dietary	

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F 565	Continued From page 12 a. Review of the 01/14/22 Resident Council (RC) Minutes revealed the following dietary concerns: The RC commented on the Dietary Department no longer taking food orders (preferences). Additionally, the kitchen had stopped ordering lactose free milk. The response to the concern was that due to the kitchen staff's old process of taking orders each day was being held and was not signed until 2/8/22.The secondary response was that the kitchen was unable to get the milk in due to shipping issues and they will get to working on it. b. Review of the 01/17/22 RC Minutes revealed the following dietary concerns: The RC commented on the Dietary Department not following their preferences and request that dietary preferences be competed again. The response to the concern was that the new Dietary Manager would complete preferences on start and was not signed until 2/8/22. c. Review of the 03/10/22 RC Minutes stated that menu options are not being taken. The response to the concern was the Dietary Department is planning on reopening the dining room and putting tickets back on the meal trays and was signed on 03/17/22. d. Review of the 03/31/22 RC Minutes stated that food preferences needed to be taken and honored again. Additionally, the RC Minutes reflected the kitchen not having lactose free milk. Thirdly, condiments were not being served on meal trays. Fourthly, RC commented silverware was not provided on some trays.	F 565	Manager ordered Lactose Free Milk on 7/24/2022. The Dietary Manager and Regional Dietary Manager reviewed and updated all residents dietary preferences on 7/24/2022. The Dietary Manager reinitiated the practice of putting tickets on each resident s meal trays on 7-15-2022. The Dietary Manager reinitiated the practice of the dietary staff instead of nursing assistants putting condiments on all meals tray on 7-18-2022. On 7-15-2022 the Dietary Manager implemented a visual inspection by the dietary staff to ensure that all meal trays have silverware. The Dietary Manager met with Resident #68 on 8-3-2022 to confirm his food preferences. The Dietary Manager met with Resident #3 on 8-3-2022 to confirm her food preferences. Resident #57 discharged from the facility on 7-29-2022. The Dietary Manager met with Resident #68 on 8-3-2022 to confirm his food preferences. 2. All residents who receive meals prepared in the kitchen are at risk. The Dietary Manager reviewed and updated all resident s dietary preferences on 8-8-2022. In addition, any residents submitting grievances or concerns identified in the Resident Council are at risk . On 8-5-2022, the Administrator reviewed the Resident Council Minutes and all Grievances back to 1-1-22 to identify any additional unresolved grievances. No additional unresolved grievances were identified.	

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F 565	Continued From page 13 The response to the concern was the Corporate Regional Dietary Manager visited residents individually for likes and dislikes on 04/06/22-04/7/22. The response to the secondary concern was to build a par of 4 cases per order of the milk. The response to the tertiary concern was packets were being distributed by the nurse aide staff and would be changed to have culinary to build trays fully in the kitchen. The fourth response was acknowledgement that silverware was missed on some trays and dietary staff should be more careful. A RC meeting was held on 07/12/22 at 2:18-4:00 PM with 9 members of the RC present. The RC reported continuing to have "food concerns" with preferences, not getting condiments and silverware consistently. Interviews with the Activity Director (AD) and Assistant Activity Director (AAD) on 07/12/22 at 4:05 PM revealed one or both staff members attend all Resident Council meetings and write up all RC concerns and provide them to the Social Worker/administrative team which discussed them during morning clinical meeting and were distributed to the appropriate departments to handle the concern. They each acknowledged that dietary concerns were always a major discussion in RC meetings. The AAD stated that it seemed they would report a concern at the meeting and preferences and lack of items seemed to reappear often. She stated if they seemed to resolve the topic for one resident it was always a concern for another attending, or it would come back up later. The AAD stated activities was provided responses by the Dietary Department but they were often delayed but she	F 565	3. On 8-8-2022, the Administrator re-educated all Department Directors including the Dietary Director on the facility policy Participation in Resident Groups and the requirement that the facility must consider the views of the Resident Council and act promptly on any grievances according to the facility policy Resident and Family Grievances. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 4. In addition, on 8-8-2022, the Administrator re-educated all Department Directors on the facility policy Resident and Family Grievances including a written follow up on all resident grievances in 48 hours and non-resident grievances in 5 working days. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. The Administrator will review the Resident Council Minutes monthly for any new or unresolved resident grievances. The Administrator will review the Grievance Tracking Log and the Grievance Binder in Morning Stand Up Meeting daily, M-F for any new or unresolved grievances. The results will be reported to the QAPI Committee monthly x 3. 5. The date of Compliance is 8-12-22.	

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would report and read them back to the members at the next meeting following her receiving a resolution response to the concern.

An interview was conducted with the Regional Dietary Manager on 07/13/22 at 1:15 PM. She indicated all resident preferences were taken and should be entered into the electronic medical record system and the tray card system. She also indicated she had not attended RC meetings before, but she was aware there had been concerns voiced regarding the Dietary Department not honoring dietary preferences, missing silverware, and not having the appropriate condiments on meal trays. She indicated she had spoken to Resident #68 regarding his preference concerns earlier on this date and believed they would be corrected, and his meal trays should reflect the preferences voiced.

A follow-up interview was conducted with Resident #3 on 07/15/22 at 8:30 AM revealed she attended Resident Council frequently and continued to have concerns with food preferences not being honored and her meal ticket not matching what she was served.

A follow-up interview was conducted with Resident #57 on 07/15/22 at 9:05 AM revealed she attended Resident Council frequently and continued to have concerns with food preferences not being honored and her meal ticket not matching what she was served

An interview was conducted with Resident #68 with the Dietary Manager present at bedside on 07/15/22 at 9:30 AM. The Dietary Manager indicated he had not attended RC meetings but

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was aware there were concerns with meal choices not being honored. He indicated he thought the issue had been corrected after the Regional Dietary Manager had spoken to Resident #68 on 07/13/22. However, the Dietary Manager had met with Resident #68 again on 07/14/22 and continued concerns were voiced. Additionally, after the observation of the meal served and the meal ticket for breakfast on 07/15/22, he acknowledged the concerns identified with preferences in RC were still an ongoing issue that needed further resolutions put into place for correction

A follow-up interview was conducted with Resident #68 on 07/15/22 at 9:45 AM revealed he attended Resident Council frequently and continued to have concerns with food preferences not being honored and his meal ticket almost never matched what he was served nor what he had identified to be his likes or dislikes.

The Director of Nursing was interviewed on 07/15/22 at 2:30 PM. She indicated all departments handling grievances should have a resolution returned to the person filing the grievance within a timely manner which she had recently been taught was 72 hours. The RC grievances should be returned to the Activity Department for them to be read at the next meeting. She stated most grievances should be handled by either her, the social worker, or the Administrator. The Grievance Coordinator should make sure an investigation has been completed regarding the concern and ensure a proper resolution with follow up is provided.

The Administrator was interviewed on 07/15/22 at 2:17 PM. He indicated he had just started at this

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F 565	Continued From page 16 facility, but he expected meal tickets to match what was on the tray 100% of the time and meal preferences to be honored to include likes and dislikes. He further explained if the facility experienced a shortage with an item on the posted meal, a meal may have to be altered. If this occurred, he expected the dietary department to change the tickets for the day and adjust the menu posted to reflect the changes so the residents can be informed in a respectful, timely manner. If there are preferences that are unavailable but a frequent request that is unable to be gotten on the routine delivery due to back order, there facility has a purchase card and it can be purchased outside the facility and charged back appropriately. He indicated he had begun working on the resolution since he had arrived by meeting with the RC and was in the process of putting new systems into place. He further indicated all grievances to include RC concerns should have a resolution provided within 72 hours. The Administrator indicated he would act as the new Grievance Coordinator in the facility.	F 565		
F 578 SS=E	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. §483.10(g)(12) The facility must comply with the	F 578		8/12/22

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F 578	Continued From page 17 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 interview the facility failed to maintain accurate advance directives throughout the medical record (Resident #47, Resident #131, Resident #22) for 3 of 5 residents reviewed for advance directives. The findings included: 1. Resident #47 was admitted to the facility on 08/20/21 and most recently readmitted on	F 578	F578 Advanced Directives 1. On 7-12-2022 Advance Directive orders and were reviewed for Resident #47 and #131 and copy of NC Most form and Golden Rod placed in binder at nurses station. On 7-12-22, Advanced Directive orders were reviewed for resident #22. The EMR reflects the accurate status of DNR for #22, and the care plan for #22 has been updated to	

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F 578	Continued From page 18 12/03/21. Review of an active care plan initiated on 09/09/21 read, Advance Directive Do Not Resuscitate Review of a physician order dated 12/04/21 read, Full code. Review of a quarterly Minimum Data Set (MDS) dated 05/04/22 revealed Resident #47 was moderately impaired for daily decision making. Review of the facility's advance directive notebook at the central nurse's station revealed no advance directive information for Resident #47. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW stated she had only been at the facility for a few weeks. She explained that when a resident admitted to the facility, she met with them to determine their code status. Once the code status was determined she let the direct care staff know, completed the required forms, and ensured the medical provider signed them. Once the required forms were signed by the medical provider, she placed the form in the binder at the nurse's station. The SW stated that since she had been at the facility, she had not had the opportunity to go though and audit the current residents advance directives to ensure all the pieces were in place and accurate. She added that the facility did care plan the advance directives, but she had not completed or updated any since she has been at the facility. The SW was unaware that Resident #47's care plan did not match his current order for full code status. She stated she would correct that as soon as possible.	F 578	remove the code status entirely. 2. On 7-12-2022, the SDC completed an audit of advance directives for all current residents to verify accuracy of the medical record. An updated copy of NC Most form and Golden Rod placed in binder at nurses station. 3. Effective 8/12/22, the SDC provided education to current facility and agency to current facility licensed nurses and department heads on advanced directives. Newly hired facility and agency licensed nurses and department heads will receive education during orientation. The admission coordinator will be responsible for obtaining current resident code status upon admission and the licensed nurse will be responsible for obtaining physician orders and updating resident care plan and Social Worker will be responsible for maintaining copy of code status with copy of NC Most form and Golden Rod in the binder at the nurses station. Code status will be reviewed quarterly or with changes. 4. The Social Worker or Administrator will monitor five (5) residents for concurrent advance directives between both the binder and Electronic Medical Record (HER). Audits will be completed two (2) times weekly for 4 weeks, then one (1) time a week for 8 weeks. The Administrator will review results of audits during QAPI monthly, and changes will be made to the plan as necessary to maintain compliance with advanced	

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F 578	Continued From page 19 The Director of Nursing (DON) was interviewed on 07/15/22 at 12:44 PM. The DON stated that when a resident's advance directives were obtained, they should be entered into the electronic medical record and then placed in the binder at the nurse's station for easy access if the computers were down or in an emergency. The DON stated if there was a care plan in place the SW should update the care plan to reflect the current residents advance directives. 2. Resident #131 was admitted to the facility on 07/05/22. Review of a Physician order dated 07/05/22 read, Full code. Review of a Social Services Assessment dated 07/08/22 revealed Resident #131 was cognitively intact. Review of the advance director binder at the nurse's station revealed a Do Not Resuscitate (DNR) form dated 07/06/22 and a Medical Order for Scope of Treatment (MOST) form that indicated DNR. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW stated she had only been at the facility for a few weeks. She explained that when a resident admitted to the facility, she met with them to determine their code status. Once the code status was determined she let the direct care staff know, completed the required forms, and ensured the medical provider signed them. Once the required forms were signed by the medical provider then she placed the form in the binder at the nurse's station. The SW stated that since she had been at the facility,	F 578	directives 5. Date of Compliance: 8/12/22	

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she had not had the opportunity to go though and audit the current residents advance directives to ensure all the pieces were in place and correct. The SW was unaware that Resident #131's advance directives did not match the current order for full code status. She stated she would correct that as soon as possible.

The Director of Nursing (DON) was interviewed on 07/15/22 at 12:44 PM. The DON stated that when a resident's advance directives were obtained, they should be entered into the electronic medical record and then placed in the binder at the nurse's station for easy access if the computers were down or in an emergency. The DON stated that all pieces of the advance directive process should match including the order and MOST form along with the accompanying DNR form if needed.

3. Resident #22 was admitted to the facility on 07/03/20.

A review of Resident #22's revised care plan dated 07/26/21 revealed the Resident's Advanced Directive was care planned as a Full Code.

A review of Resident #22's electronic medical record revealed an Advanced Directive order dated 03/31/22 for a Do Not Resuscitate (DNR).

The quarterly Minimum Data Set assessment dated 04/22/22 revealed Resident #22 was cognitively intact.

An interview was conducted with the Social Worker (SW) on 07/12/22 at 4:15 who stated that she had only been employed at the facility for a few weeks. The SW explained that the facility did

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F 578	Continued From page 21 care plan the Advanced Directives and the care plan should match the desired Advanced Directive. The SW continued to explain that there was an audit for the Advanced Directives, but she had not had an opportunity to conduct the audit. She stated she was not aware of any discrepancies in the Advanced Directive system. During an interview with the Minimum Data Set Nurse #1 on 07/12/22 at 5:59 PM the Nurse stated she had only been employed since January 2022 and explained that she was not sure who was responsible for auditing the Advanced Directives but stated that if the facility care planned the Advanced Directives then both the electronic health record and the care plan should match. An interview was conducted with the Director of Nursing (DON) on 07/15/22 at 12:29 PM. The DON explained that the residents' desired Advanced Directive should match in all areas of the medical record and if the facility chose to care plan the Advanced Directive then it should match as well. During an interview conference with the Administrator, Regional Director of Operations (RDO) and the Director of Nursing on 07/15/22 at 12:42 PM, the RDO explained that the Advanced Directives should be in the computer and should match the care plan if the facility chose to care plan the Advanced Directive. The Administrator indicated the DON would be responsible for auditing the Advanced Directive system and he would ensure compliance.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		8/12/22

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F 583	Continued From page 22 §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 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 resident (Resident	F 583	F583- Confidentiality of Records 1. On 7-11-2022, the Director of Nursing re-educated Nurse #1 who was providing	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 23 #279) by leaving confidential medical information unattended in an area visible and accessible to the public on 1 of 2 medication carts on 300 Hall. The finding included: On 07/11/22 a continuous observation was made from 3:55 PM to 4:00 PM of an unattended open computer screen on the medication cart on 300 Hall that was stationed outside of room 316. The open computer screen displayed PHI of Resident #279 which consisted of a picture, room number, diagnoses, physician, gender, allergies, date of birth, age and 2 treatment orders for wound dressing changes. During the continuous observation, 3 staff members walked by the open computer screen and had the potential to view the Resident's PHI. During the observation on 07/11/22 at 4:00 PM Nurse #1 walked up to the medication cart and explained that she had to go to the supply room to locate the correct treatment supplies for Resident #279's dressing changes. The Nurse continued to explain that she should have closed the computer screen before she left the cart because by leaving the screen activated, it displayed Resident #279's PHI accessible for public view. An interview was conducted with the Registered Nurse Consultant (RNC) and Director of Nursing (DON) on 07/15/22 at 12:29 PM. The DON explained that the Nurses should activate the privacy screen before they left the computers unattended to protect the residents' PHI.	F 583	care for Resident #279 on 7-11-22 on the requirement to protect the residents personal privacy and PHI by activating the privacy screen when leaving computers unattended . 2. All residents have the potential to be affected. On 7-11-2022 the Director of Nursing completed an audit of all medication and treatment carts. There were no additional breeches of personal privacy or potential disclosure of PHI. The privacy screen on all computers were engaged when not in use. 3. The Director of Nursing/Designee will re-educate all nursing staff on the the need to protect personal privacy and PHI including the need to keep the privacy screen engaged on all computers when not in use. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 4. The Director of Nursing/Designee will audit medication carts for protecting resident□s personal privacy and PHI by monitoring that the privacy screen on all computers are engaged when not in use 5 X week for 1 week, 3 X W for 1 week, 1 X week for a month. The results of the Privacy Audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		8/12/22

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	345283	A. BUILDING _____ B. WING _____	C 07/15/2022

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F 584	Continued From page 24	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 25 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain walls in good repair in 1 of 5 resident's rooms (room 203) on 1 of 4 halls (200 hall). The Findings Included: An observation made of room 203 on 07/11/22 at 10:46 AM revealed a large 12-inch by 12-inch scrapped area near the headboard of the resident in the bed nearest the window. The scraped area was devoid of paint with apparent missing portions of the drywall. In addition, there was a baseball sized hole in the drywall located to the left of the room's air conditioning unit. The observed damage to the wall was unchanged and unrepaired through 07/14/22. During an interview and walk around with the Maintenance Supervisor on 07/15/22 at 10:30 AM, he reported he had been with the maintenance department for approximately 2 months. He stated the facility utilized an electronic reporting system for maintenance issues. His understanding of the process was housekeeping staff would monitor resident rooms and common areas and when they noticed an issue that needed attention, the staff would report the issue to the Housekeeping Supervisor, and she would place the report in the electronic system. He reported if the request was not put into the electronic maintenance system, he would not know about it and could not repair and relied solely on the housekeeping staff reporting maintenance issues. The Maintenance	F 584	F584- Safe/Clean/Comfortable/Homelike Environment 1. On 7-14-22, the Maintenance Director repaired and painted the drywall near the resident□s headboard and air conditioning unit in Room #203. 2. All residents have the potential to be affected. On 7/15/2022 the Maintenance Director audited all resident rooms to identify a list of items that needed repair. The Maintenance Director met with the Administrator to prioritize the list of needed repairs. 6. On 8-8-2022 the Staff Development Coordinator educated all staff the need to report any needed repairs and on the process for entering maintenance requests for needed repairs. On 8-8-2022 the Administrator assigned the Department Directors a list of resident rooms to observe daily for any needed repairs. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 3. Administrator will audit resident rooms for any needed repairs 5 X week for 1week, 3 X week for 1 week, 1 X week for 4 weeks and monthly thereafter. The results of the Resident Room Audit will be reported to the QAPI Committee monthly x 3.	

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F 584	Continued From page 26 Supervisor reported he was unaware of the scraped and damaged wall in room 203 but would begin repairing the areas immediately. During an interview and walk around with Housekeeper #1 on 07/15/22 at 11:03 AM he reported he typically worked all over the building but reported he had worked several times on the 200 hall this week. He stated he was supposed to monitor rooms for maintenance issues and if he noted any, he was supposed to notify his supervisor of the issues so she could let the maintenance department know. Housekeeper #1 stated he had not noticed the scraped wall or the hole near the air conditioning unit. An interview with the Housekeeping Supervisor on 07/15/22 at 11:10 AM, she verified that her staff were supposed to be looking for maintenance issues and were supposed to report them to her so she could input the request into the electronic maintenance system. She indicated she was unaware of any maintenance issues with room 203. During an interview with the Interim Administrator on 07/15/22 at 3:17 PM he stated he had only been in the facility for a few days. He reported despite what was reported by the Maintenance Supervisor, he expected him to make routine rounds and self-identify maintenance issues and make repairs as needed. The Administrator reported he felt part of the issue revolved around the limited number of staff that have access to the electronic maintenance request system and reported he would be moving the facility to a paper-based reporting system that all facility staff could access.	F 584	4. The date of compliance is 8-12-22.	

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F 585	Continued From page 27	F 585		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 585		8/12/22

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address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 29 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to resolve a grievance for 1 of 1 resident reviewed for grievances (Resident #68). The findings included: Resident #68 was admitted to the facility on 11/9/18. A quarterly Minimum Data Set (MDS) dated 6/14/22 indicated Resident #68 is cognitively intact. Review of the grievance filed by Resident #68 on 4/11/22 indicated his concern with a lack of a contract for transportation to leave the facility. The response by Administrator #2, who was no longer employed at the facility, was that facility previously had a contract with local transportation company for residents to be able to go into the	F 585	F585- Grievances 1. The Maintenance Director will complete van training by 8-12-22. The Maintenance Director will be available to drive the facility van for weekly shopping trips as scheduled with the Activity Department until a permanent van driver can be hired to take over those duties. Resident #68 will be scheduled for the first shopping outing with the Activity Department. The first outing will be scheduled no later than September 1, 2022, and if there is any reason the outings cannot be performed using the facility van by September 1, 2022, the facility will schedule and perform the outings with a qualified, contracted, transportation vendor. 2. All residents who are able to leave in	

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F 585	Continued From page 30 community to purchase desired items, but she would verify if the contract was current or if each resident required their own contract. Additionally, the form indicated Administrator #2 would have a social worker to assist. Attempts to contact Administrator #2 were unsuccessful during the survey. An interview with Resident #68 was conducted on 07/12/22 at 1:33 PM. Resident #68 reported he was concerned that the facility no longer had a contract with the local transportation company which prevented him from being able to leave the facility to purchase items he would like. He reported that he had not been able to go to the local store to buy items for almost a year and it bothered him because he used to be able to have them pick him up and be able to leave the facility occasionally and Resident #68 said no resolution had been implemented and the ability to use the transportation was still not available to his knowledge. On 07/12/22 at 2:18 PM during a Resident Council meeting, Resident #68 vocalized the concern of not to being able to leave the facility to purchase personal items due to the facility not having a contract with the local transportation company any longer. Other members of the council vocalized they were aware and had been told they could no longer ride the local bus transportation and it was frustrating not to be able to leave the facility. An interview with the Administrator on 07/15/22 at 2:17 PM revealed he had been made aware since his arrival earlier in the week that Resident #68	F 585	the facility transportation van are at risk. The Activity Director will obtain a list of residents who are able to leave in the facility transportation van and desire to go on shopping activities by 8-12-22. The Activity Director will schedule shopping trips to allow each resident an opportunity at least monthly. 3. The Activity Director will obtain a list of residents who are able to leave in the facility transportation van and desire to go on shopping activities by 8-12-22. The Activity Director will schedule shopping trips to allow each resident an opportunity at least monthly. The Activity Director will coordinate with the Maintenance Director to schedule transportation for shopping activities. 7. In addition, on 8-8-2022, the Administrator re-educated all Department Directors on the facility policy Resident and Family Grievances including a written follow up on all resident grievances in 72 hours and non-resident grievances in 5 working days. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 4. The Administrator will review the Grievance Tracking Log and the Grievance Binder in Morning Stand Up Meeting daily, M-F, for any new or unresolved grievances. The results will be reported to the QAPI Committee monthly x 3. 5. The date of Compliance is 8-12-22.	

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F 585	Continued From page 31 was concerned with not being able to use the local public transportation and he had been working to locate the reason. He also had reviewed the grievance filed by Resident #68 on 04/11/22 and it did not appear to have a resolution included. He stated the expectation was for grievances to be presented to the social worker as soon as they were completed. The social worker would then bring them before the clinical team during morning meeting and distribute them to the appropriate department which was to handle locating and putting a resolution in place. He stated grievances resolutions should, when possible, have a solution in place within 72 hours of the appropriate department receiving the concern/grievance and a member of the staff should provide a copy of the resolution/solution to the resident or member who voiced the concern. Administrator #1 was unable to confirm whether the facility had a current contract with the transportation company and the response to the 4/11/22 grievance was inaccurate which indicated the facility had a current contract with the local transportation company.	F 585		
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	F 622		8/12/22

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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 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

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F 622	Continued From page 33 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. (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 and facility staff interviews, the facility failed to allow a resident to remain in the facility during an active discharge	F 622	F622- Transfer and Discharge Requirements	

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F 622	Continued From page 34 appeal process for 1 of 2 residents (Resident #21) reviewed for discharges. The Findings included: Resident #21 was initially admitted to the facility on 06/12/18. Review of Resident #21's quarterly Minimum Data Set assessment dated 04/24/22 revealed Resident #21 was severely impaired cognitively. The electronic and hard copy medial record for Resident #21 revealed no information about discharge planning. Review of Resident #21's electronic medical record revealed he was discharged from the facility on 05/06/22. Review of the discharge summary dated 05/06/21 revealed Resident #21 was being discharged to a sister facility due to increased wandering and behaviors. Review of the appeal hearing information revealed the hearing officer determined that Resident #21's discharge from the facility was not appropriate, sided with Resident #21, and required the facility to readmit Resident #21. An attempted phone interview was conducted with Resident #21's representative on 07/15/22 at 3:42 PM. They were unable to be reached. During an interview with Administrator #2 (who worked at the facility at the time of the discharge) on 07/14/22 at 2:59 PM, she reported she issued Resident #21 a 30-day discharge notice dated 03/30/22 due to increased behaviors and	F 622	1. Resident #21 was readmitted to the facility on 6/13/2022 after facility learned the RP appealed the discharge. 2. All residents who file an appeal for a transfer or discharge are at risk. On 7-15-2022, the Administrator completed an audit of all residents discharged in the past 30 days with no additional appeals identified. 8. The Administrator re-educated all Department Directors on the facility policy Transfer and Discharge on 8-8-2022 including the guidance that the facility will not transfer or discharge a resident while the appeal for discharge or transfer is pending, unless the failure to discharge would endanger the health or safety of the resident or other individuals in the facility. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 3. The Administrator will audit resident transfers and discharges on all residents per week x 1 week, 3 residents per week x 1 weeks, 2 residents per month for 4 weeks and monthly thereafter. The results of the Discharge/Transfer audits will be reported to the QAPI Committee. 4. The date of correction is 8-12-22.	

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wandering and felt the facility could not meet the needs of Resident #21 and keep him safe. She reported shortly after she issued the discharge notice, she was notified via letter (unable to recall the date of the letter) Resident #21's representative was appealing the discharge. She reported after she received the appeal notice, she was made aware that Resident #21's representative looked for other placement opportunities. Administrator #2 was unable to recall who made her aware of this information. She insisted when she discharged Resident #21 on 05/06/22, she was under the impression that Resident #21's representative was ok with the transfer since Resident #21's representative arrived at the facility to assist with moving Resident #21 to the new facility. She revealed she never spoke with the resident's representative personally to determine if they approved of the discharge to the sister facility. Administrator #2 stated once Resident #21 was discharged to the other facility, she thought the appeal was over, then several weeks later she received a telephone call from the discharge appeal hearing office asking if she was aware she had a discharge appeal hearing scheduled. She reported she immediately contacted Social Worker #2 and they sat in on the hearing and were told the discharge appeal was upheld (meaning Resident #21 would be allowed to remain in the facility). Administrator #2 also reported there was a blue folder in the facility that had information about the discharge planning process that was kept in her office.

During an interview with the current Administrator, Administrator #1, on 07/15/22 at 1:02 PM, he reported he had looked for the "blue folder" Administrator #2 reported having, that held the

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discharge planning information, but after 3 days of looking, he was unable to locate it.

During an interview with Social Worker #2 on 07/14/22 at 2:16PM, she reported she no longer worked at the facility but was present at the time of Resident #21's the discharge. She reported when she arrived at the facility in early April 2022 to begin working as the facility's social worker, the discharge notice had already been provided to Resident #21's representative (03/30/22) and a bed had been secured at a facility that had a secured unit due to Resident #21's increased wandering and behaviors. She stated she never received any communication from Resident #21's representative notifying her that they were appealing the discharge and stated the first time she knew the discharge had been appealed was when she was contacted to be a part of a discharge hearing.

During an interview with Director of Nursing #2 (who worked at the facility at the time of discharge) on 07/14/22 at 12:39 PM, she reported they (the administrative team) looked into transferring Resident #21 to a secured memory care unit towards the end of December 2021/early January 2022. She reported they received a bed offer at a sister facility sometime in March 2022 and had included Resident #21's representative in the discharge planning process. She reported she had multiple conversations with Resident #21's representative and insisted they were onboard with the transfer of Resident #21 to the secured unit. She also stated she was not aware that there had been an appeal filed until the hearing date.

An interview with the current Director of Nursing

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F 622	Continued From page 37 on 07/15/22 at 12:40 PM, she reported she was not at the facility at the time of Resident #21's discharge and did not know why the facility continued to discharge Resident #21 with an active appeal. She stated if the Administrator #2 was aware of a filed discharge appeal, then Resident #21 should not have been discharged until the completion of the discharge appeal process. She also reported she had assisted the Administrator #1 and attempted to locate the "blue folder" that allegedly had the discharge planning information in it with no luck. She reported she was unable to determine if discharge planning had occurred for Resident #21.	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 the Minimum Data Set (MDS) for 1 of 3 residents reviewed for indwelling catheter (Resident #47), 1 of 5 residents reviewed for unnecessary medication (Resident #21), and 1 of 1 resident reviewed for hospice (Resident #132). The findings included: 1. Resident #47 was readmitted to the facility on 12/03/21 with diagnoses that included benign prostatic hypertrophy and urinary retention. Review of the quarterly Minimum Data Set (MDS)	F 641	F641 Accuracy of Assessments 1) On 7-14-2022 the Minimum Data Set (MDS) nurse modified and resubmitted MDS assessments for Resident #47 to accurately catheter use and Resident #21 to accurately reflect psychoactive medication use. Resident #132 had a significant change in condition MDS completed to reflect hospice status. 2) On 7-15-2022 the MDS Regional Nurse completed an audit of current residents with catheters, psychoactive medications and hospice services to ensure MDS assessment was properly	8/12/22

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dated 05/04/22 indicated Resident #47 was moderately cognitively impaired, was always incontinent of bowel and bladder, and had an indwelling catheter during the assessment period. The assessment was completed by MDS Nurse #2.

MDS Nurse #2 was interviewed on 07/14/22 at 2:29 PM. MDS Nurse #2 explained that during the assessment period one Nurse Aide (NA) had documented the resident as incontinent instead of "not rated" for use of an indwelling catheter and that information prepopulated onto the MDS. This had been a mistake and an oversight. MDS Nurse #2 confirmed that residents with an indwelling catheter during the entire assessment period should be noted as "not rated" on the MDS for bladder continence.

The Director of Nursing (DON) was interviewed on 07/15/22 at 2:05 PM. She stated that all MDS assessments should be completed accurately in all areas including indwelling catheters.

2. Resident #21 was admitted to the facility on 06/13/22 with diagnoses that included dementia with behaviors, anxiety disorder, major depressive disorder, and unspecified psychosis.

A review of Resident #21's admission Minimum Data Set Assessment dated 06/20/22 revealed Resident #21 was coded as receiving an antipsychotic medication 7 of 7 days during the lookback period under section N0410. However, Resident #21 was then coded as not receiving an antipsychotic medication either routinely or on an as needed basis under section N0450.

coded. Modifications were made as identified.

3) On 7-15-2022, the Regional MDS nurse provided education to the facility MDS nurse on accurately coding residents with catheters, psychoactive medications and hospice services when completing MDS assessments (admission, annual , readmission and significant change in condition) Newly hired MDS nurses and Social Workers will receive education during orientation.

4) The Director of Nursing or designee will monitor submitted MDS assessments for accuracy of coding residents with catheters, psychoactive medications and hospice services 2 times weekly for 4 weeks; then 1 time weekly for 8 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with accurate MDS coding.

5) Completion Date: 8/12/22

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Review of Resident #21's physician orders revealed the following orders:
1. Quetiapine Fumarate tablet 25 milligrams - give one tablet by mouth at bedtime for psychosis
2. Depakote tablet delayed release 250 milligrams - give one tablet by mouth three times a day for unspecified dementia with behavioral disturbance.

An interview with MDS Nurse #1 on 07/15/22 at 10:56 AM, he reported since Resident #21 was receiving scheduled antipsychotic medications, section N0540 should have been coded accordingly. MDS Nurse #1 reported he was not working in the facility at the time the admission Minimum Data Set Assessment was completed and does not know why it was coded incorrectly. He reported he assumed it was "an oversight".

During an interview with the Director of Nursing on 07/15/22 at 12:40, she reported Minimum Data Set assessments should be completed fully and correctly. If antipsychotic medications were used, then it should have been accurately reflected on the Minimum Data Set assessment.

3. Resident #132 was admitted to the facility on 06/30/22.

Review of an Admission Assessment transfer document from the local skilled nursing facility indicated Resident #132 had been receiving hospice elected services since 03/30/22 and would transfer on hospice services to the provider in the county of the new facility upon admission.

A review of the admission census document and Hospice Election forms indicated Resident #132 was admitted under a Hospice Service on

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06/30/22.

A physician's order of clarification dated 07/04/22 revealed Resident #132 was admitted to hospice services in the current county.

An Admission Minimum Data Set (MDS) dated 07/07/22 indicated Resident #132 received hospice services while not a resident but was not reflected as receiving hospice services while a current resident.

Minimum Data Set (MDS) Nurse #1 was interviewed on 07/13/22 at 5:25 PM. MDS Nurse #1 indicated Hospice should be coded on an Admission MDS assessment if the resident was admitted under hospice services. A Significant Change Assessment would be completed to reflect a hospice election or discontinuation of the hospice services if an assessment had been completed previously.

MDS Consultant #1 was interviewed on 07/15/22 at 10:00 AM regarding Resident #132's Admission MDS dated 07/07/22. He verified the Admission MDS for Resident #132 was completed on 07/14/22 and transmitted on 07/15/22 at 9:34 AM and it had not been coded to reflect Resident #132 had received hospice services since admission to the facility. He stated the MDS should have indicated Resident #132 received hospice services both while not a resident and while a resident.

The Director of Nursing was interviewed on 07/15/22 at 2:30 PM. The DON indicated she expected all MDS assessments to be completed accurately and timely to include Hospice Services.

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		8/12/22

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F 655	Continued From page 42 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to include end of life care (hospice) to a residents' baseline plan of care when a resident had elected hospice services on admission for 1 of 1 resident reviewed for baseline care plans (Resident 132). The findings included: Resident #132 was admitted to the facility on 06/30/22 with diagnoses that included dementia. A review of the admission census document and Hospice Election forms indicated Resident #132 was admitted under a Hospice Service payor source and dated 06/30/22. Review of a Baseline Care plan completed by Nurse #2 dated 06/30/22 indicated that Resident #132 had an advance directive that reflected Resident #132 did not require end of life care nor mention Hospice care. The baseline care plan was cosigned as reviewed by the Assistant Director of Nursing on 07/04/22. The Assistant Director of Nursing (DON) was interviewed on 07/14/22 at 10:06 AM She indicated there was some confusion when Resident #132 was admitted from another facility with hospice services that was not contracted with this location and a new contract had to be signed but Resident #132 would have been	F 655	F655- Baseline Care Plans 1) On 7-14-2022 the SDC updated baseline care plan for Resident #132 to accurately document need for end-of-life care. 2) On 7-14-2022, the SDC provided education on proper completion of baseline care plans to Nurse #2. On 8-1-2022, SDC performed an audit for all baseline care plans from the prior month to ensure they had all been completed accurately. No exceptions were noted. 3) Effective 8-12-2022, SDC will provide education on proper completion of baseline care plans to all licensed nurses. Any nurse not receiving education on or before 8-12-2022 will receive the education prior to working. 4) The Director of Nursing or designee will monitor submitted baseline care plans for accuracy 2 times weekly for 4 weeks; then 1 time weekly for 4 weeks. The Administrator will report results of the monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and will make changes to the plan as necessary to maintain compliance with accurate baseline care plans.	

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F 655	Continued From page 43 considered under Hospice Services since admission and should have been reflected on the baseline care plan on admission. Nurse #2 was interviewed on 07/14/22 at 09:30 AM Nurse #2 confirmed that she had completed the baseline care plan on Resident #132 when she was admitted from another facility. Nurse #2 stated that End of Life Service should have been reflected on the baseline care plan. The Director of Nursing was interviewed on 07/15/22 at 2:30 PM and indicated end of life care should be reflected on baseline care plans for residents under Hospice Services.	F 655	5) Completion Date: 8/12/22	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		8/12/22

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F 657	Continued From page 44 (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, resident, and family interview the facility failed to invite 1 of 1 resident or family to a care plan meeting (Resident #72). The findings included: Resident #72 was readmitted to the facility on 02/12/21 and was discharged to the hospital on 07/10/22. Review of a quarterly minimum data set (MDS) dated 06/17/22 revealed that Resident #72 was cognitively intact. Review of Resident #72's medical record revealed no documentation of a recent care plan meeting. Resident #72 was interviewed via phone on 07/11/22 at 2:25 PM. Resident #72 stated that she had been a resident at the facility for years and was currently in the hospital. She stated over the last 6 months to a year she had not been invited or participated in a care plan meeting with the facility. She stated that her family visited the facility almost daily and they were always available to attend the care plan but had not received any notification of one in a long time. Resident #72's family member was interviewed	F 657	F 657- Care Plan Meetings 1. Resident #72 discharged from the facility on 7/9/2022. 2. All residents are at risk. The SW completed an audit of all residents to identify when the last Care Plan Meeting was held. The SW will complete a Care Plan Meeting Schedule for all residents who have not had a Care Plan Meeting as indicated by 8-12-22. 9. The Administrator will re-educate the Social Worker, MDS Nurse and all Department Directors on the facility policy Care Planning Resident and/or Resident Representative Participation by 8-12-22 to include the requirement for inviting the resident and/or RP to the scheduled care plan meetings. Newly hired staff or agency staff will receive education during orientation and prior to first shift worked. 3. The Director of Nursing/Designee will audit for Care Plans and Resident/RP Participation for 5 residents weekly x 4 weeks, 3 residents weekly x 4 weeks, then 2 residents weekly x 4 weeks. The results of the Care Plan Audit will be reported to the QAPI Committee monthly	

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F 657	Continued From page 45 via phone on 07/11/22 at 2:49 PM. The family member stated that while Resident #72 was in the facility he visited almost daily. The family member stated that it had been "a good while" since he recalled being invited or participated in a care plan meeting. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW explained she had only been at the facility for a few weeks. The SW stated that since she had been at the facility, she had not made it to the point where she was completing care plan meetings with the family or resident. She stated she believed someone else was handling that. The former Director of Nursing (DON) was interviewed via phone on 07/14/22 at 12:19 PM. The former DON stated she was at the facility from February 2022 until the end of June 2022. She stated that when she came to the facility in February 2022, they did not have a SW, and no one was setting up care plan meetings with the resident or family. She explained that when the facility got a SW in April 2022, she and the SW began arranging care plan meeting with the resident and family but stated she was only the member of nursing management, and she could not attend every meeting that was held but did try to attend some of them. The former DON stated she did not recall having a care plan meeting with Resident #72 or her family while she was in the facility. The former SW was interviewed on 07/14/22 at 2:21 PM who confirmed she worked at the facility from April 2022 to July 2022. She stated that she coordinated the care plan meetings at the facility and would invite the resident and family. The	F 657	x 3. 4. The date of correction is 8-12-22.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 46 former SW stated that she did not have the opportunity to coordinate any care plan meetings for Resident #72 while she was in the facility and was unable to tell me the last time Resident #72 had a care plan meeting with the facility. MDS Nurse #2 was interviewed on 07/14/22 at 2:29 PM. She explained that the facility did not have a MDS nurse, and she and a co-worker traveled to the facility every other week to keep the assessments up to date. MDS Nurse #2 stated that they did not handle the care plan meeting with the residents or family and stated the former DON had been working at getting those caught up before she left the facility. The DON was interviewed on 07/15/22 at 1:18 PM. The DON stated that she had only been at the facility for 2-3 weeks and indicated that the SW was coordinating care plan meeting with the resident and family. She stated she had not been involved in a care plan meeting with Resident #72 since she came to work at the facility. The Administrator was interviewed on 07/15/22 at 3:00 PM and stated that he had only been at the facility for 2 days. The Administrator stated that it was "best practice to invite resident and families to care plan meetings."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		8/12/22

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F 658	Continued From page 47 by: Based on observations, record review, staff, resident, and Wound Physician interview the facility failed to transcribe and carry out treatment orders to a non-pressure related wound for 1 of 2 residents reviewed with non-pressure skin issues (Resident #39). The findings included: Resident #39 was readmitted to the facility on 02/02/22 with diagnoses that included: non-pressure ulcer of buttock and left heel. Review of a quarterly minimum data set (MDS) dated 05/10/22 revealed that Resident #39 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #39 required application of non-surgical dressing other than to feet and no pressure ulcers were noted during the assessment reference period. Review of a physician order dated 07/02/22 read; cleanse right lower leg with wound cleanser, pat dry, apply calcium alginate and dry dressing daily and as needed. Review of a Wound Physician (WP) progress note dated 07/06/22 read in part: Resident #39 has a wound to right distal shin that was full thickness wound. The wound measured 0.8 centimeters (cm) x 0.8 cm with light serous exudate (drainage). The dressing treatment plan read: Leptospermum honey apply once daily for 30 days with gauze or border gauze daily for 30 days. Review of a nurses note dated 07/06/22 at 1:56	F 658	F658- Services Provided Meet Professional Standards 1. The Wound MD saw Resident #39 on 7/6/2022. Resident #39 had new orders for wound treatment on 7/6/2022. The wound treatments have been provided as ordered and documented in the TAR. 2. All residents with wound orders are at risk. The Director of Nursing completed an audit of all residents with wound care orders on 7-13-2022 comparing the orders with the most recent Wound MD progress note. No additional transcription errors were noted. 10. On 7-13-2022, the Director of Nursing re-educated the Assistant Director of Nursing on the policy Wound Treatment Management and the importance of following physician orders including the need to carefully review the Wound MD Progress Notes for all new Wound Care Orders in a timely manner. The Assistant Director of Nursing is responsible to enter new MD Wound Care Orders into PCC as indicated. Going forward, any newly hired ADONs will receive education on the facility's Wound Treatment Management Policy during orientation. The DON will provide the training to any newly hired ADONs. 3. The Director of Nursing will audit the MD Wound Progress Notes on a weekly basis x 12 weeks to ensure proper transcription of Wound Care Orders. The	

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F 658	Continued From page 48 PM read, resident seen this am by wound doctor. No new orders at this time. Signed by Nurse #9. Review of the Treatment Administration Record (TAR) for July 2022 revealed the following: Right lower leg cleanse with wound cleanser, pat dry, apply calcium alginate and dry dressing daily and was initialed by staff indicating the dressing had been completed as ordered since 07/02/22. An observation and interview were conducted with Resident #39 on 07/11/22 at 12:02 PM. Resident #39 was resting in bed. He stated that he currently had a wound to his right shin and proceeded to pull the sheet off and revealed a piece of gauze covering the wound with no date noted. Resident #39 stated that he saw the WP every week and he ordered whatever he felt was appropriate for the area but was not sure what he had ordered during his last week visit. An observation and interview were conducted with the WP on 07/13/22 at 11:08 AM. The WP stated he visited the facility weekly and rounded with a staff member. He explained that Resident #39 had several non-pressure related issues including his right shin which he saw last week an ordered Leptospermum honey every day and as needed. The WP removed the dressing that was in place to the right shin and took measurements. The wound measured 0.5 cm x 0.3 cm, and the WP indicated that there was improvement noted. He stated that he dictated his orders in his wound report which were automatically uploaded into the facility's electronic medical record generally the same day as his visit and he expected the staff to enter the order and carry those orders out. The Assistant Director of Nursing (ADON) was	F 658	results of the Wound Care Orders audit will be reported to the QAPI Committee monthly x 3. 4. The date of correction is 8-12-22.	

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F 658	Continued From page 49	F 658		

interviewed on 07/13/22 at 11:50 AM. The ADON stated that she reviewed the WP reports that were automatically uploaded into the electronic system each week and updated any orders that had been changed. She stated that at times the staff member who rounded with the WP was aware of the order change, would take care of entering those orders. The ADON stated that she was playing catch up and had not a chance to review the reports from last week and was currently working her way through them.

Nurse #2 was interviewed on 07/14/22 at 3:13 PM. Nurse #2 confirmed that she had cared for Resident #39 on 07/10/22 and 07/11/22 and had completed his wound treatments as ordered. She could not recall what the specific treatments where but recalled put a dressing on Resident #39's right shin as directed. Nurse #2 stated that the WP usually visited the facility weekly but she did not round with him so she would complete wound treatments per the resident current order on the TAR.

An attempt to speak to Nurse #9 who rounded with the WP on 07/06/22 was attempted on 07/15/22 without success.

The Director of Nursing (DON) was interviewed on 07/15/22 at 12:57 PM. The DON stated that the ADON was ultimately responsible for reviewing the weekly wound report from the WP and ensuring the orders were entered and carried out. The DON explained that when the WP visited on 07/06/22 he verbally told Nurse #9 no new orders but when his report came in there was new orders. The DON stated that the ADON should have reviewed the WP progress note and ensured the correct order was entered and

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F 658	Continued From page 50 carried out.	F 658		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, and staff interviews the facility failed to provide incontinence care before the resident wet through her brief and bed linens (Resident #72) and provide assistance to maintain personal hygiene (Resident #131) for 2 of 5 resident reviewed for activities of daily living. The finding included: Resident #72 was readmitted to the facility on 02/12/21 with diagnoses of Guillain Baree syndrome and dementia and was discharged from the facility on 07/09/22. Review of the quarterly Minimum Data Set (MDS) dated 06/17/22 revealed Resident #72 was cognitively intact and required extensive assistance of one staff member for toileting and was always incontinent of bladder. Review of the facility daily assignment sheet for 07/09/22 for 3:00 PM to 11:00 PM revealed that Nurse Aide (NA) #3, NA #10, and NA #11 were assigned on the unit where Resident #72 resided. An interview was conducted with Resident #72's family member on 07/11/22 at 1:58 PM who	F 677	F677 ADL Care for Dependent Residents 1) Resident #72 discharged from the facility on 7-9-2022. Resident #131 continues to receive showers per plan of care. Shower schedule and care plan updated accordingly. 2) On 7-18-2022, the Director of Nursing completed an audit via questionnaire (cognitively intact) and/or observation (cognitively impaired) of all residents to ensure incontinence care and bathing/hygiene care needs are being met. Shower schedules reviewed and updated per resident plan of care. 3) Effective 8/12/22, the Staff Development Coordinator (SDC)/Designee completed education with current facility and agency staff on providing Activities of Daily Living (ADL) care to dependent residents. The licensed nurse and/or nurse aide assigned to resident are responsible for completing routine rounds throughout their shift to ensure ADL care needs are met including incontinence care and completion of	8/12/22

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F 677	Continued From page 51 stated on 07/09/22 she received a video call from Resident #72 at 9:08 PM. She stated that Resident #72's call light was on, and she needed to be changed. She stated that Resident #72 stated that she had turned the call light about 20 minutes prior to calling the family member and had reported that the last time she had received incontinent care was at 1:30 PM. The family member stated that while on the video call with Resident #72 a staff member who she could not recall their name came in and when Resident #72 stated she needed to be changed the staff member stated that she was not assigned to Resident #72 that shift and then exited the room. The family member stated that about 10 minutes later another staff member came into the room to provide incontinent care but by that time Resident #72, her brief, and bed were all wet and needed to be changed (via the video call). Resident #72 was interviewed via video call on 07/11/22 at 2:25 PM and stated on 07/09/22 she had remained in bed all day. She stated that the staff had woken her up at 5:30 AM to provide incontinent care and then again at 1:30 PM. Resident #72 stated that she did not see the staff again until around 9:15 PM (time on her tablet device) when a staff member came in to answer her call light that had been a while but when she told the staff member, she needed to be changed the staff member stated that she was not assigned to take care of Resident #72 that shift and then left the room. Resident #72 stated that about 10 minutes later a new staff member came in to provide incontinent care to her. She stated by that time she was wet and so was her bed and everything had to be changed. NA #4 was interviewed on 07/11/22 at 5:57 PM	F 677	showers per resident plan of care. Newly hired facility and agency nursing staff will receive education during orientation and prior to first shift worked. 4) The Director of Nursing (DON)/Designee will monitor 5 residents for ADL care via questionnaire (cognitively intact) and/or observation (cognitively impaired) and Electronic Medical Record (EMR) review, including incontinence care and bathing. Monitoring will be completed three (3) times weekly for four (4) weeks then, weekly for eight (8) weeks. The DON will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with ADL care for dependent residents. Completion Date: 8/12/22	

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F 677	Continued From page 52	F 677		

and confirmed that she had cared for Resident #72 on first shift (7:00 AM to 3:00 PM) on 07/09/22. She stated that when she arrived for her shift, she checked Resident #72 who was dry and then she checked her again around 11:00 AM and she was still dry. NA #4 stated that she provided incontinent care to Resident #72 around 1:30 PM before she left for the day. She added she was slightly wet, but her bed was dry so, she only had to change her brief.

Nurse Aide (NA) #3 was interviewed on 07/12/22 at 2:33 PM and reported she was working on 07/09/22 from 3:00 PM to 11:00 PM and had answered Resident #72's call light because her assigned NA was on break. NA #3 stated that she answered the call light at approximately 9:30 PM and was not sure who was assigned to care for Resident #72 because that was her first day in the facility in 2 years. NA #3 stated that when she answered her call light Resident #72 was on the phone with her family member and was wet and needed to be changed. She stated that her bed was also wet and needed to be changed, they (sheets) were not saturated "but I did not want to leave them soiled." NA #3 did not know which staff member had previously answer Resident #72's call light or how long the call light had been on.

NA #10 was interviewed on 07/13/22 at 11:02 AM and confirmed that she worked 07/09/22 from 3:00 PM to 11:00 PM on the unit where Resident #72 resided but stated she did not provide any care to her. She stated she answered her call light around dinner time, and she wanted a cup of ice and that was given to her, she did not mention needing incontinent care at that time.

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NA #11 was interviewed on 07/13/22 at 1:19 PM and confirmed she worked on 07/09/22from 3:00 PM to 11:00 PM on the unit where Resident #72 resided. She stated she was assigned to sit with another resident on that unit and did not provide any care to Resident #72 during that shift.

The Regional Nurse Consultant was interviewed on 07/15/22 at 1:18 PM. She stated that the facility staff were to round on each resident before and after meals, at bedtime and as needed. She stated that Resident #72 should have been checked before and after her evening meal and again at bedtime and if her call light was on then as requested.

2. Resident #131 was admitted to the facility on 07/05/22 with diagnoses that included chronic obstructive pulmonary disease.

Review of Social Service assessment dated 07/08/22 revealed Resident #131 was cognitively intact.

Review of the facility's shower schedule revealed Resident #131 was scheduled for showers on Wednesday and Friday on first shift.

Review of Resident #131's documentation report for bathing dated July 2022 indicated that on first shift on Wednesday 07/06/22 Nurse Aide (NA) #4 documented a partial but did not specify if it was a bed bath or shower and on Friday 07/08/22 NA #5 documented a bed bath.

An observation and interview were conducted with Resident #131 on 07/11/22 at 10:28 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was

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standing up in spots and appeared almost wet with oil and the bottom of her feet were black with dirt. She stated that her showers were scheduled for Wednesday and Friday morning, but she had not had a shower since she admitted on 07/05/22. She stated she asked a staff member this morning for a shower, and they told her it was not her shower day, but she did not know who the staff member was. Resident #131 stated she had an appointment on Friday, and she wanted to be sure she had a shower before her appointment.

An observation and interview were conducted with Resident #131 on 07/12/22 at 11:08 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was standing up in spots and appeared almost wet with oil and the bottom of her feet were black with dirt. She again stated she had asked for a shower yesterday and did not get it.

NA #5 was interviewed on 07/13/22 at 7:59 AM and confirmed that she cared for Resident #131 on Wednesday 07/06/22. She stated that Resident #131 had just admitted to the facility the day before and she did not have any clothes with her. She stated she set her up with a wash basin and wash cloth so she could wash her face. NA #5 stated that Resident #131 did not have a shower that day, but she did not know why, she stated "maybe there was a shower team or maybe she had not been added to the shower sheet yet" but again did not know why Resident #131 did not have a shower that day. NA #5 stated that their assignment sheet indicated who was scheduled for a shower that day and if there was no shower team then the NAs on the hall were responsible for completing the scheduled showers.

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F 677	Continued From page 55 NA #4 was interviewed on 07/13/22 at 10:28 AM and confirmed that she cared for Resident #131 for the first time on Friday 07/08/22. NA #4 stated that she did not give Resident #131 a shower on Friday 07/08/22 and she was not sure if there was a shower team or not. She stated that recently they have "been lucky" and had a shower team often but did not recall if they had one on 07/08/22. NA #4 stated that there was a paper at the nurse's station that told them who was scheduled for a shower each day, but she could not recall why Resident #131 did not get one on 07/08/22. NA #1 was interviewed on 07/14/22 at 2:04 PM who confirmed that she cared for Resident #131 on 07/11/22 and 07/12/22. She stated that on 07/11/22 Resident #131 did ask for a shower but it was not her scheduled shower day and was told her that her scheduled shower day was on Wednesday, and she seemed ok with that. The Director of Nursing (DON) was interviewed on 07/15/22 at 12:41 PM. The DON stated that showers were scheduled based upon room or by resident preference and should be given as scheduled. If the resident requested a shower on a non-scheduled shower day, then it should be given by the staff as requested by the resident.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		8/12/22

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F 689	Continued From page 56 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family, staff, and Medical Director interviews the facility failed to protect a resident from falling from the bed to the floor during personal care for 1 of 3 resident reviewed for supervision to prevent accidents (Resident #72). The findings included: Resident #72 was readmitted to the facility on 02/12/21 and was discharged to the hospital on 07/09/22. Review of the quarterly Minimum Data Set (MDS) dated 06/17/22 revealed that Resident #72 was cognitively intact and required one person assistance with bed mobility, toilet use, and personal hygiene. The MDS also indicated Resident #72 had no falls since the previous assessment. Review of a fall care plan updated 06/28/22 read; the resident was at risk for falls related to impaired mobility. The goal stated that resident would be free of falls through the review date. The interventions were: be sure the residents call light was within reach and encourage the resident to use it for assistance as needed (added 06/29/20), follow the fall protocol (added 06/29/20), and when resident was in bed place all necessary personal items within reach (added 06/29/20). Review of an incident report dated 07/09/22 read	F 689	F689- Free of Accidents Hazards/Supervision/Devices 1. Resident #72 sustained a fall in the facility on 7-9-22. Resident #72 was discharged to the Emergency Department on 7-9-22 and did not return to the facility. On 7-11-2022, the Director of Nursing re-educated NA #3 on safety measures with bed mobility including placing all supplies in reach before attempting task and ensuring resident is safely positioned at all times. 2. All residents requiring assistance with bed mobility are at risk. The Director of Nursing completed an audit of all residents to determine the level of assistance with bed mobility. No additional issues were identified. 3. Effective 8-12-22, the Staff Development Coordinator/Designee completed education with current facility staff and agency staff on the facility policy Accidents and Supervision. Education included safety with bed mobility including using placing all supplies in reach before attempting task, ensuring resident is safely positioned at all times, and using 2-person assistance with bed mobility as indicated. Newly hired facility and agency staff will receive education during orientation and prior to first shift worked.	

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F 689	Continued From page 57 in part, per Nursing Assistant (NA) #3; she was changing resident's brief and turned to throw the soiled brief in the trash when resident started sliding off her bed on the right side. NA #3 stated she quickly got to resident's side and assisted resident to the floor. Resident was observed by staff lying on her left side on the floor, face down. Resident #72 complained of left arm, left shoulder, and left foot pain. The Medical Doctor (MD) was notified, and resident was transferred to the Emergency Room (ER) for evaluation per family request. Event occurred around 9:45 PM. Resident description: unable to give description. Immediate action taken: transported to the ER for evaluation and staff educated resident to be 2 person assist with positioning and incontinent care. The report was completed by Nurse #4. Review of a hospital Emergency Department Discharge Report dated 07/11/22 read in part; Discharge Diagnoses: Fall: accidentally fell out of bed after being turned while being changed by nursing home-landed on her left side. X-ray of the tibia, fibula, left femur and pelvis did not show any evidence of acute fracture or dislocation involving the pelvis, left femur, or left leg. Resident #72's family member was interviewed on 07/11/22 at 1:58 PM. The family member stated that on 07/09/22 around 9:00 PM she received a video call from Resident #72. A staff member entered the room and was going to change Resident #72, she took the tablet that was on video call and sat it on the side of the bed. The family member stated that she could hear the interaction between Resident #72 and the staff member who she did not know. The family member stated she heard the staff member tell Resident #72 that this was her first night in the	F 689	4. The Director of Nursing/Designee will monitor all resident falls in Morning Clinical Meeting Daily M-F on-going for proper level of supervision to prevent an accident. Results of monitoring will be reported to the facility's Quality Assurance and Performance Improvement Committee (QAPI). Plan will be reviewed by the Committee and amended as warranted for effectiveness. 5. The Plan of Correction Date is 8-12-22.	

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facility and asked Resident #72 to turn onto her side and shortly after she heard Resident #72 say "I am sliding I am going to fall" and the staff member replied, "no honey you're not going to fall your fine" and then the family stated we heard Resident #72 fall out of bed to the floor.

An observation and interview with Resident #72 were conducted on 07/11/22 at 2:25 PM via video conference call. Resident #72 was resting in a hospital bed and was dressed in a gown. Resident #72 was observed to have extensive dark purple bruises to her left hand, wrist, and arm as well as her chest and both breast. Resident #72's left knee was slightly swollen with some faint bruising noted. She recalled the evening of 07/09/22 and stated a new staff member who she had never seen before and did not know her name answered her call light that had been on for a while. When the staff member came into my room, I told her I was wet and had not been changed since 1:30 PM so she proceeded to put both of my side rails down and turned me to one side and then the other and the next thing I know I "am screaming I am falling," and the staff member stated "no you're not" and then I fell to the floor. Resident #72 stated when she fell her left wrist, arm, and knee where hurting but she was mainly uncomfortable being on the hard cold floor. She added that she did not want to return to the facility and the hospital was working on finding her a new place to go.

Nurse #4 was interviewed on 07/11/22 at 6:11 PM. Nurse #4 stated that on 07/09/22 she was sitting at the nurse's station when NA #3 came to the desk and reported that she was providing incontinent care to Resident #72, and she turned to throw the soiled brief in the trash can and

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Resident #72 started sliding off the bed on the right side and she quickly got to her and assisted her to the floor. Nurse #4 stated that Resident #72 generally kept her bed high and when she entered the room the bed was "kind of high." Nurse #4 stated she and Nurse #18 entered Resident #72's room she was lying on the floor face down on her left side. One of her legs was bent behind the other and she complained of left arm, shoulder, and foot pain. Her family member was on the phone during this time when she fell. Nurse #4 stated that they put a pillow under her head and covered her with a blanket and called EMS. Resident #72 had no visible injuries at the time. Nurse #4 could not recall if the side rails were up or down but stated that NA #3 was alone in the room with Resident #72 at the time of the fall

An observation of Resident #72's room was conducted on 07/12/22 at 2:00 PM. Resident #72's bed was the bed closest to the door Resident #72's bed was a standard pressure reducing mattress. The empty bed on the other side of the room was an air mattress that had been deflated and was not made. No personal effects were noted on that side of the room.

Nurse #18 was interviewed on 07/12/22 at 3:37 PM and confirmed he was working on 07/09/22 on the unit where Resident #72 resided but was working the other end of the hall. He stated he was doing treatments on his end of the hall when NA #3 approached him to tell me Resident #72 had fallen out of bed. Nurse #18 stated he entered the room at the same time as Nurse #4 did and found Resident #72 face down on her left side Resident #72 complained of left shoulder pain and left leg pain, and we placed a pillow

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under head and made her comfortable until EMS arrived. Nurse #18 stated Resident #72 had no visible injuries at the time, but her family was on the phone during this time and was also reassured that we were going to assess Resident #72 and were going to send her to the ER for evaluation.

Nurse #17 was interviewed on 07/12/22 at 3:49 PM and confirmed that she was the nurse responsible for Resident #72 on 07/09/22 when she fell. The NA reported that she was providing incontinent care to Resident #72 and she "rolled out of bed but she tried to break her fall and lowered her to the floor." Nurse #17 stated when she entered Resident #72's room she found her lying on her left side on the floor, she appeared to be scared and was complaining of left arm and knee pain. Nurse #17 stated that Resident #72 was on the phone with her family at the time of the fall. She stated she tried to assess Resident #72 from the position she was in and did not see any visible injuries, her vital signs were obtained, and we put a pillow under her head and called EMS who was there very quickly and transported Resident #72 to the ER.

NA #3 was interviewed on 07/12/22 at 2:33 PM and confirmed she was working on 07/09/22 when Resident #72 fell. She explained that 07/09/22 was her first time working at the facility since 2020 and first time rendering any care to Resident #72. Resident #72's call light was on, and she answered the light since her assigned NA was on lunch. NA #3 stated that Resident #72 was on the phone with her family at the time, but I proceeded to provide incontinent care to her. She stated that she began to provide care to Resident #72 because her brief was wet and so was her

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sheets and bed. She added that Resident #72's side rails were up, and she left them up. She started out on Resident #72's right side and turned her towards the left side of bed, NA #3 stated she tucked the bed sheets that were wet, and the soiled brief under Resident #72 and then went to Resident #72's left side and turned her toward the right side of the bed. NA #3 stated she pulled the soiled linen and brief out from under Resident #72 and turned to her left to throw them in the trash can and Resident #72 started to fall out of bed "I tried to grab her and could not grab her because she was too far over, and I was not able to catch her" so I moved to the other side of the bed and tired to break her fall. NA #3 stated that Resident #72's feet rolled out of the bed first and then her top half which was what she was able to assist to the floor. Resident #72 was screaming to get help and Nurse #17 was the first person in the hallway she came to. Nurse #17 immediately went to the room and NA #3 explained she then went to find Resident #72's nurse. Her family member that was on the phone did not want us to touch her, she wanted EMS called. We were able to obtain vital signs which were stable, and she had no bleeding. Resident #72 was complaining of arm pain but she "was scared for the most part." EMS arrived quickly and before she left, she told her family that she would call them once she got to the hospital.

The Director of Nursing (DON) was interviewed on 07/15/22 at 1:18 PM. The DON stated that when a resident fell in the facility they were immediately assessed by a nurse. If there is visible injury they would contact the MD before moving the resident. If the resident hit their head, we would not move them. Vital signs were obtained, pain was evaluated, skin assessment

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F 689	Continued From page 62 including range of motion should all be completed post fall. The staff should be documenting, completing the appropriate paperwork, and notifying the appropriate people. The DON stated that they had looked at Resident #72's fall but "not in depth." The goal of the facility was to determine root cause of the fall and implement an intervention to prevent the fall from happening again. The Administrator was interviewed on 07/15/22 at 11:45 AM. The Administrator had been at the facility for 2 days and stated "there was no doubt in my mind that she needed two person in that room". The MD was interviewed on 07/15/22 at 10:26 AM. She stated that she had been told that Resident #72 had fallen out of bed. She indicated that Resident #72 had a lot of stiffness and would not be able to react in an appropriate amount of time. The MD stated that educating the staff on how to properly turn a resident and to ensure all supplies were within reach before starting the task were so important to keep the resident safe. She continued to say that Resident #72 did not have behaviors of falling on her own accord and could not get up on her own.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		8/12/22

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F 690	Continued From page 63 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to ensure that a urinary catheter bag was kept below a resident's bladder and ensure a resident's urinary catheter tubing was kept in a free-flowing position to prevent backflow for 2 of 2 residents reviewed for catheters. Resident #55 and Resident #131. The Findings Included:	F 690	F690- Bowel/Bladder Incontinence, Catheter, UTI 1. On 7-13-2022, the Director of Nursing assessed both Resident #55 and Resident #131□s foley catheters and both drainage bags and tubing were both positioned below the level of the bladder to prevent backflow.	

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F 690	Continued From page 64 1. Resident #55 was readmitted to the facility on 12/02/21 with diagnoses that included retention of urine, and obstructive and reflux uropathy. A review of Resident #55's annual Minimum Data Set assessment dated 06/02/22 revealed he had moderately impaired cognition. Resident #55 was coded as having a catheter. Review of Resident #55's physician orders revealed an order dated 09/15/21 for catheter used for [benign prostatic hyperplasia] (prostate gland enlargement) with urinary retention obstruction and reflux uropathy. Review of Resident #55's care plan last updated on 04/11/22 revealed a care plan for [Resident #55] has indwelling catheter due to urinary retention and obstructive uropathy. Interventions included ... Position catheter bag and tubing below the level of the bladder. An observation of Resident #55 on 07/11/22 at 10:04 AM revealed Resident #55 was sitting in his wheelchair at the door of his room. His urinary catheter bag was observed to be between his left hip and side of his wheelchair on the seat, with the tubing running up from the bottom of his pants leg to his urinary catheter bag. The observation included urine in the urinary catheter tubing. An additional observation made of Resident #55 on 07/11/22 at 3:52 PM revealed the urinary catheter bag to remain in the same position it was observed at 10:04 AM, firmly placed between his left hip and the side of his wheelchair on the seat, above his bladder with his catheter tubing running	F 690	2. All residents with foley catheters have the potential to be affected. On 7-13-2022 the Director of Nursing audited all residents with foley catheters and no additional issues with foley catheter drainage bags or tubing. 3. On 7-18-2022, the Staff Development Coordinator re-educated all nursing staff on the facility policy Catheter Care including ensuring that urinary drainage bags are located below the level of the bladder to discourage backflow of urine. Newly hire facility and agency staff will receive education during orientation and prior to the first shift worked. 4. The Director of Nursing/Designee will monitor all foley catheters 3 x weekly x 4 weeks, 2 times weekly x 4 weeks, 1 x weekly x 4 weeks. The results of the Foley Catheter audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	

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up his leg from the bottom of his pants. The observation included urine in the urinary catheter tubing.

During an interview with NA #4 on 07/14/22 at 5:08 PM, he reported catheter bags should be attached to the bottom of a resident's wheelchair, below the bladder. He reported this was to ensure the urine would freely flow into the catheter bag. He stated it was the responsibility of every staff in the facility to ensure that catheter bags were kept where they should be, below the bladder.

Attempts to contact the nurse who was scheduled on 07/11/22 for Resident #55 were unsuccessful.

An interview with the Director of Nursing on 07/15/22 at 12:40 PM revealed catheter bags should be kept below the bladder of the resident and if the resident was in a wheelchair, the catheter bag should be attached to the bottom of the wheelchair, below the resident's bladder while keeping the catheter bag from touching the floor. She reported all staff were responsible for ensuring catheter bags were below resident's bladder.

2. Resident #131 was admitted to the facility on 07/05/22 with diagnoses that included acute kidney failure and hydronephrosis.

Review of a Baseline Care Plan dated 07/05/22 indicated that Resident #131 had an indwelling catheter and the interventions included position catheter bag and tubing below the level of the bladder.

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Review of a Social Services Assessment dated 07/08/22 indicated that Resident #131 was cognitively intact.

An observation of Resident #131 was made on 07/11/22 at 10:30 AM. Resident #131 was resting on her bed. Her indwelling catheter tubing and bag were observed to be coming out over the top of the waist band on her pants and was not below the level of the bladder.

An observation of Resident #131 was made on 07/12/22 at 11:07 AM. Resident #131 was resting on her bed. Her indwelling catheter tubing and bag were observed to be coming out over the top of the waist band on her pants and was not below the level of the bladder.

An observation of Resident #131 was made on 07/13/22 at 8:45 AM. Resident #131 was ambulating back from the bathroom. Her indwelling catheter tubing and bag were observed to be coming out over the top of the waist band on her pants and was not below the level of the bladder.

Nurse Aide (NA) #9 was interviewed on 07/14/22 at 9:35 AM and confirmed she was working with Resident #131. She stated she provided catheter care and emptied the bag earlier in her shift. She stated that when Resident #131 was in bed she ensured the bag was secured to the bed or rail so that it could flow properly, and the tubing should be running down her pant leg not over the waist band of her pants. NA #9 stated that Resident #131 can walk to the bathroom without assistance so she would go down to her and educate her on the proper placement of the catheter tubing and bag.

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NA#1 was interviewed on 07/14/22 at 2:04 PM. NA #1 confirmed that she had cared for Resident #131 on 07/11/22 and 07/12/22. She stated that the catheter bag and tubing should always be kept below the level of the bladder and off the floor. NA #1 stated that on 07/12/22 she noticed that Resident #131's catheter tubing and bag were over the waist of her pants, so she had corrected it and ran the tubing down Resident #131's pant leg and secured the bag to the bed rail but had not noticed it on 07/11/22.

Nurse #6 was interviewed on 07/14/22 at 3:09 PM. Nurse #6 stated the catheter bag and tubing of all indwelling catheters should be kept below the level of the bladder and off the floor. When the resident was resting in bed the indwelling catheter bag should be secured to the bed rail or frame to ensure that it was kept below the bladder but off the floor.

An observation and interview were conducted with Resident #131 on 07/15/22 at 8:45 AM. Resident #131 was ambulating back from the bathroom and sat down on the side of the bed and hung her catheter bag on the frame of the bed. Resident #131 explained that she used to live at assisted living facility and had never had a catheter before and was not sure what to do with the tubing or bag so she was doing the best she could with it. She stated that one of the staff members had come and told her that her tubing needed to go down her pant leg and to always keep the bag off the floor.

The Director of Nursing (DON) was interviewed on 07/15/22 at 12:46 PM. The DON explained that a leg bag may be appropriate for Resident

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F 690	Continued From page 68 #131 but until then, the catheter tubing and bag should be kept below the level of the bladder.	F 690		
F 695 SS=E	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 reviews, staff, Resident and Physician interviews the facility failed to secure an oxygen tank that was stored upright on the floor in a resident room (Resident #63), failed to provide water humidification for 2 residents (Resident #31 and Resident #39), failed to clean the oxygen concentrator filters for 1 resident (Resident #31) and failed to maintain oxygen tubing in good working condition for 1 resident (Resident #39) for 3 of 4 residents reviewed for respiratory therapy. The findings included: A review of the facility's Oxygen Safety policy dated 11/01/20 revealed "it is the policy of this facility to provide a safe environment for residents, staff and the public". *Oxygen Storage #c revealed Cylinders will be properly changed or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling,	F 695	F695- Respiratory/Trach Care and Suctioning 1. On 7-15-2022, the Director of Nursing verified the following Oxygen Safety measures were in place: a. Resident #63 oxygen tank was stored in an approved storage device. b. Resident #31 water humidification was in place and the Oxygen concentrator filter was clean. c. Resident #39 had water humidification in place and the oxygen tubing was replaced and in good working order. 2. All residents who receive Oxygen therapy are at risk. On 7-15-2022, the Director of Nursing audited all residents on Oxygen therapy. No additional issues were identified. 3. On 7-15-2022, the Staff Development	8/12/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 69 whether connected, unconnected, full, or empty. 1. Resident #63 was admitted to the facility on 03/01/21 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated 06/10/22 revealed her cognition was moderately intact and required oxygen therapy. On 07/11/22 at 3:55 PM an observation and interview were conducted with Resident #63. An full tank of oxygen was stored between the bedside table and the wall. The oxygen tank was standing up right and was not secured. The Resident wore an oxygen cannula in her nares that delivered between 2.5 to 3 liters of oxygen per minute delivered by the oxygen concentrator in the room. Resident #63 explained that she needed the oxygen because she became too winded when she went out to smoke. The Resident also explained that the free standing oxygen tank had been in her room for as long as she could remember. On 07/12/22 at 9:21 AM an observation of the free standing oxygen tank remained stored unsecured between the bedside table and the wall. The Resident was not in the room. On 07/12/22 at 2:09 PM an observation was made of the free standing oxygen tank stored unsecured in the room. An interview and observation was conducted with Nurse #7 on 07/12/22 at 4:08 PM who confirmed she was generally the nurse for Resident #63. The Nurse explained that Resident #63 wore continuous oxygen at 2 liters per minute because	F 695	Coordinator/Designee re-educated all nursing staff on the facility policy Oxygen Safety and Oxygen Administration. Education included proper storage of oxygen cylinders, cleaning of filters, replacement of water humidification bottles, and changing of nasal cannula tubing weekly and prn. Newly hire facility and agency staff will receive education during orientation and prior to the first shift worked. 4. The Director of Nursing/Designee will complete auditing of Oxygen with 5 residents weekly x 4 weeks, 3 residents weekly x 4 weeks, and 2 residents weekly x 4 weeks. The results of the Oxygen Audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	

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she easily became short of breath on exertion without the oxygen. Nurse #7 was accompanied to Resident #63's room and acknowledged the free standing full oxygen tank stored unsecured in the corner of the Resident's room. The Nurse explained that the oxygen tank should have been taken to the oxygen supply storage room because of the potential for explosion and retrieved a transport cart for the oxygen and returned the oxygen tank to the storage room.

On 07/15/22 at 12:29 PM an interview was conducted with the Director of Nursing (DON) who explained that the oxygen tank should not have been stored in the Resident's room and should have been stored in the oxygen supply room until needed.

During an interview with the Administrator on 07/15/22 at 2:33 PM he explained that the oxygen tanks should be stored in the oxygen supply room and residents with oxygen should have physician orders to support the use of the oxygen.

2. Resident #31 was admitted to the facility on 09/08/21 with diagnoses that included chronic obstructive pulmonary disease.

a. A review of Resident #31's medical record revealed a physician order dated 03/06/22 to change oxygen and nebulizer tubing (label and date tubing), humidification bottle, bag cover and clean filters on concentrator every week on Sunday night shift.

The quarterly Minimum Data Set assessment dated 05/06/22 revealed Resident #31 was cognitively intact and required oxygen therapy.

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On 07/11/22 at 11:08 AM an interview and observation were made of Resident #31. During the interview an observation was made of the condition of the filters on the oxygen concentrator which were gray and were covered with white dust that rippled when touched. The Resident explained that the nurses changed her nasal cannula once a week but did not clean the filters. The Resident stated she cleaned the filters when she felt like it.

On 07/11/22 at 1:48 PM an interview was conducted with Nurse #5 who confirmed she was assigned to Resident #31. The Nurse explained that the filters on the oxygen concentrators were cleaned once a week by third shift. She continued to explain that it was every nurses' responsibility to check the oxygen setting, condition of the oxygen tubing, humidification and condition of the filters every time they go into the residents' rooms. The Nurse accompanied the Surveyor to Resident #31's room to view the condition of the oxygen filters. The Nurse acknowledged the dirty filters on each side of the oxygen concentrator and stated, "oh no, it shouldn't be like that, it should be cleaned because the dirt could impede the flow of clean oxygen". The Nurse cleaned the oxygen filters.

b. On 07/14/22 at 3:11 PM an observation was made of Resident #31's water humidification bottle which was dry and completely void of water. The humidification bottle was dated 05/08/22. The Resident was not in her room.

During an interview with Nurse #2 on 07/14/22 at 3:15 PM the Nurse acknowledged that she was the one that changed the water humidifier bottle on 05/08/22 and stated the bottle had been dry all

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day. The Nurse explained that the facility had been out of water humidification bottles for the oxygen concentrators for a while and she had asked the Central Supply Clerk (CSC) to order them, but he ordered the wrong type. The Nurse accompanied the Surveyor to the medical supply room where there was an ample supply of water humidification bottles, but they were the wrong type of bottles to fit Resident #31's oxygen concentrator. The Nurse stated the CSC was aware of the water humidification bottle shortage.

On 07/14/22 at 3:29 PM an interview was conducted with Resident #31 in the Resident's room. The Resident explained that when she went to bed last night (07/13/22) she only had a little water left in the humidification bottle and when she woke up that day (07/14/22) the water was gone. The Resident continued to explain that she needed the humidification because without it she developed sores in her nose. The Resident stated she did not have sores as of that time, but her nares were dry. The Resident stated the facility was aware that there was no water in the humidification bottle and that the facility had trouble getting the correct water humidification bottles for her concentrator.

During an interview with the Central Supply Clerk (CSC) on 07/14/22 at 4:14 PM he stated he had only been the CSC since 05/2022 and received no orientation to ordering the supplies. He explained that in June he realized he was not ordering the oxygen humidification bottles fast enough so he ordered some and realized they were the wrong type than what they needed. The CSC continued to explain that he ordered the correct type that day (07/14/22) and the supply should be delivered on Sunday 07/17/22 or

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Monday 07/18/22.

On 07/15/22 at 8:16 AM an interview was conducted with the Regional Director of Operations (RDO) who explained that the facility conducted an audit and inventory of the water humidification bottles and obtained what was needed from their sister facility as well as ordered more supply. The RDO indicated that when the facility realized they would not have enough supply to get through to the next delivery, they should have obtained the water humidification supply from the sister facility.

An interview was conducted with the Medical Director who was Resident #31's Physician on 07/15/22 at 10:53 AM. The Physician explained that the purpose for the water humidification was for comfort and to reduce dryness and sinusitis. She continued to explain that if the resident complained of dryness then they needed the humidification especially if they used oxygen long term which Resident #31 did. The Physician stated she would expect the facility to maintain a supply of water humidification bottles.

An interview was conducted with the Director of Nursing (DON) on 07/15/22 at 12:20 PM. The DON explained that the oxygen filters were cleaned once a week and more often when needed. She indicated the nurses should be checking the filters when they go into the residents' room. The DON also explained that it was unacceptable for the facility to run out of water humidification bottles and indicated the facility had retrieved an ample supply from their sister facility.

During an interview with the Administrator,

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Regional Director of Operations (RDO) and the Director of Nursing on 07/15/22 at 12:42 PM the Administrator stated the facility should have utilized all their resources for the water humidification bottles and would do so going forward. He explained that he would educate the staff to call him when they ran out of supplies.

3. Resident #39 was readmitted to the facility on 02/02/22 with diagnoses that included heart disease.

Review of a physician order dated 03/04/22 read; oxygen at 2 liters per minute via nasal canula or to maintain oxygen saturation level above 92%. Change oxygen tubing and humidification bottle every week on Sunday night.

Review of the quarterly Minimum Data Set (MDS) dated 05/10/22 revealed that Resident #39 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed Resident #39 had no shortness of breath and used oxygen during the assessment reference period.

Review of the MAR dated July 2022 revealed the following: change oxygen tubing and humification bottle every week on Sunday night. On Sunday 07/03/22 Nurse #10 initialed the order indicating the change had occurred and on Sunday 07/10/22 Nurse #11 initialed that she had completed the change.

An observation and interview were conducted with Resident #39 on 07/11/22 at 12:04 PM. Resident #39 was resting in bed with an oxygen canula in his nose that was connected to a concentrator sitting beside his bed. The

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humidification water bottle was attached and was noted to be empty and was dated 05/09/22. Resident #39 stated that they were supposed to change the water bottle and oxygen tubing every week on Sunday night, but it had been months since it had been changed and the tubing was stretched out from taking it on/off and it did not stay in place. The prongs of the oxygen canula were cloudy in color and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears.

An observation and interview were conducted with Resident #39 on 07/12/22 at 11:02 AM. Resident #39 was resting in bed with an oxygen canula in his nose that was connected to a concentrator sitting beside his bed. The humidification water bottle was attached and was noted to be empty and was dated 05/09/22. Resident #39 stated that they still had not changed his oxygen canula and the prongs of the canula remained cloudy and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears. Resident #39 stated that he had asked a nurse to please replace the oxygen tubing she obtained the tubing and put it in his drawer of his nightstand but did not change it. Resident #39 did not know who the nurse was.

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An observation and interview were conducted with Resident #39 on 07/13/22 at 12:00 PM. Resident #39 was in bed with his oxygen canula in his nose, the prongs of the canula remained cloudy and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears.

Nurse #2 was interviewed on 07/14/22 at 9:42 AM and confirmed she was responsible for Resident #39. She explained that the oxygen tubing and water bottles were changed weekly on Sunday or as needed. She added that they usually changed the tubing and water bottle on night shift but during her shift she would periodically check the oxygen concentrator. Nurse #2 explained that humidification water bottles were changed when they were empty. Nurse #2 was asked to check Resident #39's humidification water bottle at his bedside which was empty and dated 05/09/22, she stated "oh my". Resident #39 stated to Nurse #2 that his oxygen tubing was loose and would not stay in place and the pads of the ear loops were gone as well. Nurse #2 replied that she would get him some new tubing but stated that the facility did not have the correct humification water bottle to change out. Nurse #2 stated that the Central Supply clerk had ordered the wrong bottles.

Nurse #10 was interviewed on 07/14/22 at 1:16 PM who stated that she did not work in the facility on 07/03/22. She stated she did not recall ever

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F 695	Continued From page 77 changing Resident #39's water bottle or oxygen tubing. Nurse #11 was interviewed on 07/15/22 at 9:53 PM who confirmed she had cared for Resident #39 on 07/10/22 but could not recall if she had changed his oxygen tubing or humification water bottle. The Administrator and Director of Nursing (DON) were interviewed on 07/15/22 at 1:00 PM. The DON stated that Resident #39's oxygen tubing should have been changed every Sunday night and the humidification water bottle when it was empty. She stated that a lot of the agency staff were just clicking things off without really checking what they were clicking. The Administrator added that this was their opportunity to fix the issue because the facility had a sister facility within walking distance, and we should have used our resources to get what our residents needed.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		8/12/22

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F 761	Continued From page 78 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (100 hall cart and 200 hall cart) and 2 of 2 medication rooms (front medication room and back medication room). The facility also failed to remove unopened insulin pens for 1 of 3 medications carts (100 hall cart) reviewed. The findings included: Review of the manufacture recommendations for Novolog (insulin) Flex pen read in part; unopened flexpen's should be stored in the refrigerator between 36- and 46-degree Fahrenheit. 1. An observation of 100 hall medication cart was made on 07/14/22 at 10:20 AM with Nurse #2. The observation revealed the following expired medications: -Ondansetron (antiemetic) 4 milligrams (mg) 8 tablets that expired on 04/30/22. -Cogentin (used to treat Parkinson's disease) 1 mg 10 tablets that expired on 06/11/22.	F 761	F761- Label/Store Drugs and Biologicals 1. On 7-15-2022 all expired medications removed from all medication carts and medication rooms and returned to the pharmacy. All unopened insulin vials/pens were returned to the pharmacy. 2. All residents are at risk for the same deficient practice. Effective 8-12-22, the Director of Nursing verified that all medication carts and medication rooms were free of expired medications. All medication carts were free of unopened insulin vials/pens. 3. On 7-15-2022, the Staff Development Coordinator/Designee re-educated all nurses and Medication Aides on the facility Medication Storage , Insulin Pens, and Unused Medication Return policies. Education included checking med carts weekly for expired medications, proper storage of medication including removal and return of expired medications, proper	

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F 761	Continued From page 79 -Pantoprazole (used to treat reflux) 2 mg/1milliliter (ml) bottle that contained approximately 200 ml of liquid that expired on 07/06/22. The observation further revealed 5 unopened vials of Novolog Flex pen 100 units/ml that were stored in the medication cart. Nurse #2 was interviewed on 07/14/22 at 10:39 AM. Nurse #2 confirmed that she was responsible for the 100-hall medication cart. She stated that she was not sure if the nursing management staff went through the medication carts looking for expired medications. She stated that the hall nurses were expected to go through the medication carts if they had the time. Nurse #2 stated that she had not had the time to go through the medication cart because she had gotten report late and needed to get started with the medication pass and was unaware of the expired medications. She also stated that the 5 vials of unopened insulin should be kept in the medication room in the refrigerator and that whoever received them from the pharmacy just placed them in the wrong spot. The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication carts weekly to remove any expired medications. She added that the nursing management team and the pharmacy staff also tried to help the hall nurses as much as possible. The DON explained the expired medications should have been removed from the medication cart and returned to the pharmacy and the unopened vials of insulin should have been placed in the refrigerator until opened then it could be left on the medication	F 761	storage of unopened insulin vials/pens, and return of expired medications to the pharmacy. Newly hired facility and agency nursing staff will receive education during orientation and prior to first shift worked. 4. The Director of Nursing/Designee will audit medication carts and medication rooms 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, then 1 x weekly x 4 weeks. The results of the Medication Storage Audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	

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cart for use.

2. An observation of the 200-hall medication cart was made on 07/14/22 at 3:34 PM with Nurse #8. The observation revealed the following expired medication:

- Pramipexole (used to treat Parkinson's disease) 0.5 milligrams (mg) 15 tablets that expired on 06/30/22.
-Ibuprofen (pain reliever) 600 mg 12 tablets that expired on 06/14/22.

An interview was conducted with Nurse #8 on 07/14/22 at 3:40 PM. Nurse #8 stated that at times she would go through the medication cart and check for expired medications but had not noticed the medications that were expired. She explained that she worked through an agency and worked on a different cart each time she was in the building, and it was hard to keep each medication cart neat and orderly and remove all the expired medications without all of the staff assisting.

The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication carts weekly to remove any expired medications. She added that the nursing management team and the pharmacy also tried to help the hall nurses as much as possible. The DON explained the expired medications should have been removed from the medication carts and medication rooms and returned to the pharmacy. The DON added that the pharmacy staff visited the facility the first week of July 2022 and had not discovered the expired medications.

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3a. An observation of the front medication room was made on 07/14/22 at 12:47 PM with the Unit Secretary. The observation revealed the following expired medication:

-Nicotine Transdermal patch (smoking cessation) 14 patches that expired 01/21.
-2 unopened bottles of Multivitamin 100 tablets each that expired 06/22.

The Unit Secretary was interviewed on 07/14/22 at 12:52 PM. The Unit Secretary stated that she would take the expired medications and discard them but was unsure who was responsible for checking the medication rooms for expired medications.

b. An observation of the back medication room was made on 07/14/22 at 3:38 PM with Nurse #8. The observation revealed the following expired medication:

-3 boxes of 100 Bisacodyl (laxative) suppositories that expired 05/22.

An interview was conducted with Nurse #8 on 07/14/22 at 3:40 PM. Nurse #8 stated that she did not know what to do with the expired medications, but she would find out. She was also unaware of who was responsible for checking the medication rooms.

The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication rooms weekly to remove any expired medications. She added that the nursing management team and the pharmacy staff also tried to help the hall nurses as much as possible.

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F 761	Continued From page 82 The DON explained the expired medications should have been removed from the medication rooms and returned to the pharmacy. The DON added that the pharmacy staff visited the facility the first week of July 2022 and had not discovered the expired medications.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to honor a residents' food choices for 2 of 2 residents reviewed for meal preferences (Resident #68 and Resident #31). The findings included: 1. Resident #68 was admitted to the facility on 11/9/18. A quarterly Minimum Data Set (MDS) dated 6/14/22 indicated Resident #68 was cognitively intact. An observation and interview with Resident #68 on 07/13/22 at 11:30 AM revealed Resident #68	F 806	F806- Resident Allergies, Preferences, Substitutes 1. On 7-15-2022, the Dietary Manager interviewed Resident #68 and Resident #31 to obtain their personal food preferences and allergies and verified that they were entered correctly in the dietary tray system. The Dietary Manager made a follow up visit on 8-3-2022 to Resident #68 and Resident #31 who both indicated that their dietary preferences were followed. Resident #31 stated that she had not received any corn products on her tray since 7-1-2022. 2. All resident who receive meals from	8/12/22

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F 806	Continued From page 83 sitting in his wheelchair which was positioned next to his bed. He had a stack of meal tickets spread out over his bed for review. He shared his concern the facility was no longer providing residents with food item choices and did not listen and abide by his meal preferences when they delivered his trays daily. Resident #68 stated he was often having to return to the dietary department in order to ask for items he had requested to be delivered or ask for an alternate meal when food was delivered which he had vocalized that he did not like. Resident #68 held up a meal ticket dated 07/10/22 with a note hand-written by staff that informed him the staff member responsible for ordering the requested item did not order it and the item was unavailable to him as requested. The meal ticket included 2 pimento cheese sandwiches which he indicated they sent to him on both his lunch and dinner trays daily. Resident #68 stated the dietary department did not deliver the traditional menu items to him on days when they aligned with his food preferences in addition to the pimento cheese sandwiches which caused him to be tired of only eating the same sandwich so often. An observation and interview on 07/13/22 at 1:01 PM revealed Resident #68 had been delivered his meal tray. He provided the meal ticket and his untouched meal tray for comparison. The ticket indicated 2 pimento cheese sandwiches, yellow frosted cake and potato chips. Observation of the meal tray revealed he had not been sent neither the cake nor potato chips and an alternative dessert had been provided that he stated was not a food preference for substitution. An interview with the Regional Dietary Manager on 07/13/22 at 1:15 PM. She indicated all resident	F 806	the kitchen are at risk. Effective 8-12-22, the Dietary Manager audited the meal tray system to ensure that all resident preferences and allergies are correctly entered into the tray system. No additional issues were identified. 3. On 7-15-2022, the Dietary Manager re-educated all dietary staff on the facility policy Dining and Food Preferences. Education included food allergies, food dislikes, and food and fluid preferences; careful preparation of the meal tray to match the tray card; and timely alternate meal and/or beverage delivery. Newly hired dietary staff will receive education during orientation and prior to the first shift worked. 4. The Dietary Manager/Designee will audit resident meal trays with 5 residents weekly x 4 weeks, 3 residents weekly x 4 weeks, then 2 residents weekly x 4 weeks. The results of the Meal Tray Audit will be reported to the QAPI Committee monthly x 3. 5. The plan of correction date is 8-12-22.	

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preferences were taken and should be entered into the electronic medical record system as well as a separate tray card system for preferences. She indicated she had spoken to Resident #68 regarding his preference concerns earlier on this date and believed they would be corrected, and his meal trays should reflect the preferences voiced. The RDM said the facility had two separate systems each resident's preferences had to be included in and often they were not transcribed into both systems which caused inconsistencies. She explained the Dietary Manager was new in their role and she believed the former Dietary Manager had not been diligent in ensuring the resident preferences were transcribed into both systems.

An observation and interview with the Dietary Manager on 07/15/22 at 9:30 AM were conducted in Resident #68's room. Resident #68 was lying in bed with his breakfast tray setup in front of him on an overbed table. The breakfast tray included bacon and the meal ticket indicated he was to be served sausage. He was also served hot cereal and Resident #68 stated his preference was a named cold cereal. The Dietary Manager indicated he was aware there were concerns with meal choices not being honored. He indicated he thought the issue had been corrected after the Regional Dietary Manager had spoken to Resident #68 on 07/13/22 and he had met with Resident again on 07/14/22, but appeared after the breakfast observation on this date, the concerns identified with preferences in RC were still an ongoing issue that needed further resolutions put into place for correction.

A follow-up interview was conducted with Resident #68 on 07/15/22 at 9:45 AM revealed he

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attended resident council frequently and continued to have concerns with food preferences not being honored and his meal ticket almost never matched what he was served nor what he had identified to be his likes or dislikes.

The Administrator was interviewed on 07/15/22 at 2:17 PM. He indicated he had just started at this facility, but he expected meal tickets to match what was on the tray 100% of the time and meal preferences to be honored to include likes and dislikes. He further explained if there was an item on the menu for the day and a meal had to be changed the tickets must be changed and the menu must reflect the changes and be posted so the residents can be informed in a respectful, timely manner. If there were preferences that were not included on the dietary departments routine meal purchase orders such as potato chips or others that the dietary department was unable to be obtained on the routine delivery due to back order, the facility had a purchase card and it could be purchased outside the facility and charged to the purchase card.

2. Resident #31 was admitted to the facility on 09/08/21.

A review of Resident #31's medical record revealed a physician order dated 09/08/21 for a regular diet, regular texture and regular/thin liquid consistency. The medical record also indicated an allergy to corn products.

The quarterly Minimum Data Set assessment dated 05/06/22 revealed Resident #31 was cognitively intact.

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An observation and interview were conducted with Resident #31 on 07/11/22 at 11:10 AM. The Resident's untouched breakfast tray was still in the Resident's room which contained a bowl of corn flakes (plastic wrapping intact) and an unopened carton of reduced milk. The breakfast meal ticket indicated the Resident was on a regular diet with no restriction and she was to receive rice krispies and whole milk. The meal ticket also indicated Resident #31 had allergies to corn and corn products. Resident #31 explained that she had voiced her food preference to a dietary staff member several weeks ago that she only wanted rice krispies and milk for breakfast and it did not matter if the milk was whole milk or reduced milk. The Resident continued to explain that she could not eat the corn flakes because she had an allergy to corn products that caused her to have an upset stomach.

During an observation and interview with Resident #31 on 07/13/22 8:29 AM the Resident's breakfast meal tray was sitting on the bedside table with a bowl of corn flakes which were still wrapped in plastic wrap and an unopened carton of whole milk. The meal ticket on the tray stated the Resident should have received rice krispies. Resident #31 stated that was what they brought her to eat for breakfast and they knew she can't eat corn products.
07/13/22 8:45 AM an interview was conducted with the Dietary Manager (DM) who reviewed Resident #31's breakfast meal ticket and stated she should have received the rice krispies. The DM also indicated he needed to educate the dietary staff about being more careful to read the meal tickets and put what the ticket called for on the meal trays.

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F 806	Continued From page 87 On 07/13/22 at 8:50 AM an interview was conducted with Dietary Aide #1 who confirmed that she worked on 07/11/22 and 07/13/22 for the breakfast meal preparation. The DA explained that the process was for the DA to call out to the cook what was needed for the meal tray and the cook would put the items on the meal trays. The DA stated she knew Resident #31 liked 2 corn flakes and 2 milks for breakfast and that was what she called out for the cook. The Surveyor showed the DA the 2 breakfast meal tickets for 07/11/22 and 07/13/22 that indicated no corn flakes and the preference for rice krispies. An interview was unable to be obtained from the Cook scheduled for 07/11/22 and 07/13/22. An interview was conducted with the Senior Regional Culinary Manager (SRCM) on 07/13/22 at 10:54 AM. The SRCM explained that she conducted an audit on all the residents in house in June 2022 to obtain their food preferences and stated she specifically remembered obtaining Resident #31's food preference for breakfast. The SRCM indicated that the dietary staff would be reeducated to the meal preparation process which included making sure the items placed on the meal trays matched what was on the meal tickets.	F 806		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		8/12/22

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F 812	Continued From page 88 (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 interview the facility failed to label and date opened food and discard outdated food for 2 of 2 nourishment rooms (300 and 600 Hall) and failed to ensure dietary staff wore hair restraints that fully covered their hair while working in the kitchen. The findings included: 1) A review of the facility's undated "Use and Storage of Food Brought in by Family or Visitors" policy indicated it was the right of the residents of this facility to have food brought in by family or other visitor, however, the food must be handled in a way to ensure the safety of the resident. 2. All foods brought in by the family or visitors that were already prepared must be labeled with the resident's name and dated. b. The prepared food must be consumed by the resident within 3 days. c. If the food is not consumed by the resident within 3 days the facility staff will discard the food. An observation was made on 07/11/22 at 10:16 AM of the 300 and 600 Hall Nourishment rooms	F 812	F812- Food Procurement, Store/Prepare/Serve- Sanitary 1. On 7-11-2022 the Dietary Manager discarded undated/unlabeled and outdated food from the Nourishment Rooms on 300 and 600 Hall. On 7-13-22, the Senior Regional Culinary Director educated the Dietary Aide #2 to ensure that the hair net covered her head and all her hair. On 7-13-2022 Dietary Aide #2 obtained a larger hair net sized large enough to cover her head and all her hair. 2. All residents who receive meals or snacks from the kitchen are at risk. 3. On 7-15-2022, the Housekeeping Manager/Dietary Manager educated all Dietary and Housekeeping Staff on Date Marking for Food Safety and Dietary Employee Personal Hygiene policies.	

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F 812	Continued From page 89 and refrigerators accompanied by the Dietary Manager (DM). The discovery revealed: 300 Hall Nourishment Room Refrigerator *2 open undated boxes of thickened lemon flavored sweetened tea, both approximately one forth full. The boxes indicated to refrigerate for 7 days after opening, the box was warm to touch. The boxes were stored on the ice cart in the nourishment room. *an open, undated and unlabeled strawberry flavored drink *an unidentified desert not labeled and dated 06/08/22 *a box of open and undated liquid thickener in the refrigerator *a resident labeled biscuit dated 06/05/22 *an open, undated and unlabeled pepper steak dinner *an open, unlabeled and undated tub of chocolate ice cream *an undated and unlabeled ice cream shake that had a black substance growing in it *2 unlabeled pepperoni hot pockets *an unlabeled box of shrimp alfredo 600 Hall Nourishment Room Refrigerator *an open and undated box of thickened water *an open and unlabeled tub of butter During an interview with the Dietary Manager (DM) on 07/11/22 at 10:40 AM he explained that dietary was responsible for rotating the food products that were brought from the kitchen and that housekeeping was responsible for cleaning the refrigerators which included discarding the outdated foods in the nourishment rooms. The DM continued to explain that the person putting food products in the refrigerators should be	F 812	Education included proper dating and labeling, discarding outdated food, and Dietary Staff Hygiene including hair and beard restraints. Newly hired Dietary and Housekeeping staff will receive education during orientation and prior to first shift worked. 4. The Dietary Manager will audit the Nourishment Rooms and Dietary Staff Hygiene 5 x weekly x 4 weeks, 3 times weekly x 4 weeks, then 2 x weekly x 4 weeks. The results of the Dietary Audit will be reported to the QAP Committee monthly x 3. 5. The plan of correction date is 8-12-22.	

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F 812	Continued From page 90	F 812		

responsible for dating and labeling food products.

On 07/12/22 at 5:12 PM an interview was conducted with the Environmental Supervisor (ES) who explained that the housekeeper assigned to the hall with the nourishment room was responsible to clean the refrigerator and removed old foods more than 3 days old. The ES continued to explain that anyone putting foods in the refrigerator should ensure the foods were dated and labeled with the residents' name.

An interview with Housekeeper #2 was conducted on 07/13/22 at 11:19 AM who was assigned to 300 Hall. The Housekeeper explained that she educated to only clean the top of the refrigerator on the hall she worked, and she did not clean out the old food from the refrigerator.

On 07/13/22 at 10:54 AM an interview was conducted with the Senior Regional Culinary Director (SRCD) who explained that the dietary staff should keep the foods provided by the kitchen rotated out when they replenish the supply in the nourishment room refrigerators. The SRCD indicated it was the housekeeping department's responsibility to clean the refrigerators and discard the old foods.

An interview was conducted with the Administrator on 07/15/22 at 2:33 PM who explained that he expected the refrigerators to be cleaned daily and the outdated food products be removed from the refrigerators per the facility policy.

2) An observation was made on 07/13/22 at 9:55 AM of a Dietary Aide #2 (DA) who was unloading the clean dishes and putting them away. The DA

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F 812	Continued From page 91 had long black braided hair that hung almost to her waist. The DA wore a hair net that only covered her head and her braids hung freely out of the hair net. On 07/13/22 at 10:54 AM an observation was made of Dietary Aide #2 with her hair hanging out of the hair net. The Senior Regional Culinary Director (SRCD) was present during the observation and addressed the issue with the DA. The DA explained that she did not have a hair net large enough to accommodate all her hair and the SRCD responded by informing her that she would get a larger hair net and contain her hair. The SRCD explained that it was not acceptable for the DA to not have all her hair in a hair net. An interview was conducted with the Administrator on 07/15/22 at 2:33 PM who explained that the Dietary Aide should have had a hair net large enough to contain all her hair in the hair net.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure the area around the dumpsters was free of debris and the dumpster doors were closed for 3 of 3 dumpsters reviewed. The findings included: During a tour of the dumpster area on 07/11/22 at 9:47 AM with the Dietary Manager (DM) the	F 814	F814- Dispose Garbage and Refuse Properly 1. On 7-11-2022, the area around Dumpster #1, Dumpster #2 and Dumpster #3 was cleaned of all debris and litter. The doors to all three dumpsters were securely fastened.	8/12/22

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F 814	Continued From page 92 observations revealed: dumpster #1 was approximately half full of trash bags and the side door was only half way closed, dumpster #2 was approximately three fourths full of trash bags and the side door was one fourth way open and dumpster #3 was designated for card board products that was half full and the side door was one fourth way open. The ground surrounding the dumpsters was littered with debris that included: face masks, gloves, plastic baggies, water bottles, spoons, screws, paper, plastic grocery bags, straws and shredded briefs. An interview conducted with the Dietary Manager (DM) on 07/11/22 at 10:00 AM revealed he thought the dumpsters were emptied three times a week but was not sure which days. The DM stated the dumpster doors should remain closed and he tried to clean the ground surrounding the dumpsters when he had extra time but stated everyone should clean up after themselves. During an interview with the Maintenance Supervisor (MS) on 07/11/22 at 10:11 AM the MS explained that the dumpsters were emptied three times a week on Monday, Wednesday and Friday. The MS continued to explain that the maintenance department tried to keep the dumpster area clean from debris, but the maintenance department did not work on the weekend. The MS stated everyone should clean up after themselves and the dumpster doors should remain closed.	F 814	2. All residents have the potential to be affected. 3. On 7-15-2022 the Administrator re-educated the Dietary Manager and the Maintenance Director on the facility policy Disposal of Garbage and Refuse. Effective 8-12-22, the Staff Development Coordinator educated all staff on the facility policy Disposal of Garbage and Refuse. Education included keeping the doors to the dumpsters and the area surrounding the dumpsters clean so that accumulation of debris and insect/rodent attractions are minimized. Newly hired facility and agency staff will receive education during orientation and prior to the first shift worked. 4. The Maintenance Director will audit the Dumpsters 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, then 2 x weekly x 4 weeks. The results of the Dumpster Audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		8/12/22

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F 867	Continued From page 93 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility ' s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 4/15/21 and the complaint investigation completed on 01/14/22. This was for four repeat deficiencies in the area of advance directives, home like environment, medication storage, and food storage that were originally cited on 04/15/21 during a recertification and complaint survey and for three repeat citations in the area of respect and dignity, grievances, and activities of daily living that were originally cited on 01/14/22 during a complaint investigation. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F550: Based on record review, resident, family, and staff interview the facility failed to treat a resident in a dignified manner by not responding to a call light and meeting the resident's request which led to the resident's brief and bed being wet with urine requiring an entire bed change. The resident stated this made her feel unwanted, belittled, and uncared for by everyone except her	F 867	F867- QAPI/QAA Improvement Activities 1. On , 8-4-2022, the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance (QAPI) Committee as well as the on-going compliance issues regarding F550, F565, F578, F584, F677, F761, F812, and F880. 2. All residents have the potential to be affected. On 8-4-2022, the Regional Director of Clinical Services educated the Director of Nursing on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying and correcting repeat deficiencies related to F550, F565, F578, F584, F677, F761, F812, and F880. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds. On 8-4-2022, the Regional Director of Operations educated the Nursing Home Administrator on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying and correcting repeat deficiencies related to F550, F565, F578,	

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F 867	Continued From page 94 family or 1 of 2 residents reviewed for dignity (Resident #72). During the complaint investigation of 01/14/22 the facility failed to maintain a resident's dignity by not providing incontinence care which made the resident feel miserable and embarrassed (Resident #1) and failing to assist a resident with toileting that resulted in the resident being incontinent of bowel making her feel embarrassed and ashamed (Resident #4) for 2 of 3 resident reviewed for dignity and respect. F565: Based on Resident Council Meeting Minutes, resident and staff interviews, the facility failed to resolve dietary grievances that were reported in the Resident Council meetings (1/14/2022, 1/17/2022, 3/10/2022, and 3/31/2022). During the complaint investigation of 01/14/22 the facility failed to communicate the resident councils concerns with the nursing department, failed to respond to and provide resolution to grievances filed during the resident council for 2 of 10 months of minutes reviewed. F578: Based on record review and staff interview the facility failed to maintain accurate advance directives throughout the medical record (Resident #47, Resident #131, Resident #22) for 3 of 5 residents reviewed for advance directives. During the recertification survey of 4/15/21 the facility failed to maintain accurate advance directives throughout the medical record for 1 of 15 residents reviewed for advance directives. F584: Based on observations and staff	F 867	F584, F677, F761, F812, and F880. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds. On 8-4-2022, the Administrator contacted the QIO and requested assistance in enhancing the facility□s QAPI process. The program director for the QIO responded and she had the state QIO director reach out to the facility. A meeting date is pending. 3. On 8-4-2022, the Administrator educated the QAPI committee members consisting of, the Medical Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Infection Preventionist, Unit Coordinators, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy Consultant, on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. 4. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff monthly x 3. Corporate	

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F 867	Continued From page 95 interviews, the facility failed to maintain walls in good repair in 1 of 5 resident's rooms (room 203) on 1 of 4 halls (200 hall). During the recertification survey of 04/15/21 the facility failed to clean sticky bedroom flooring in a resident room for 1 of 19 rooms. The facility failed to repair walls with exposed metal dented L shaped corner brackets and chipped drywall for 3 of 19 rooms. The facility failed to repair peeling and cracked laminate on nightstands for 2 of 19 rooms. The facility failed to remove a broken toilet seat riser with visible sharp metal railing and 4 plastic pointed brackets that had been bolted to the commode seat for 1 of 19 rooms. These observations occurred on 2 of 4 halls. F677: Based on record review, resident, family, and staff interviews the facility failed to provide incontinence care before the resident wet through her brief and bed linens (Resident #72) and provide assistance to maintain personal hygiene (Resident #131) for 2 of 5 resident reviewed for activities of daily living. During the complaint investigation of 01/14/22 the facility failed to perform incontinence care for 2 of 3 dependent residents sampled for activities of daily living. F761: Based on observations, record review, and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (100 hall cart and 200 hall cart) and 2 of 2 medication rooms (front medication room and back medication room). The facility also failed to remove unopened insulin pens for 1 of 3 medications carts (100 hall cart) reviewed.	F 867	oversight will validate the facility□s progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.	

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F 867	Continued From page 96	F 867		

During the recertification of 04/15/21 the facility failed to remove lose and unsecure pills/capsule, failed to remove debris of paper shaving and rubber bands, failed to remove 2 unopened and undated insulin pen from 3 of 5 medication carts reviewed for medication storage.

F812: Based on observations and staff interview the facility failed to label and date opened food and discard outdated food for 2 of 2 nourishment rooms (300 and 600 Hall) and failed to ensure dietary staff wore hair restraints that fully covered their hair while working in the kitchen.

During the recertification survey of 04/15/21 the facility failed to properly label open food items in 1 of 1 freezer, 1 of 1 refrigerator, and 1 of 2 nourishments rooms. The facility also failed to date, and discard expired thicken water from 1 of 1 reach in refrigerator.

F880: Based on observation, record review, and staff interview the facility failed to disinfect a glucometer (used to check a resident's blood glucose level) after use per the manufacture's recommendations which resulted in the potential for cross contamination for 2 of 2 residents (Resident #39 and Resident 25).

During the complaint investigation of 01/14/22 the facility failed to follow the CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 2 of 4 nurses administered medications to 3 of 3 residents without donning eye protection and 1 of 3 Nurse Aides failed to wear eye protection while providing patient care. The facility further failed to follow infection control guidelines when 1 of 1 wound

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F 867	Continued From page 97	F 867		

care personnel failed to remove gloves and perform hand hygiene during 2 of 3 wound observations.

During the recertification survey of 04/15/21 the facility failed to develop and implement a policy to follow guidelines established by the Center for Disease Control and Prevention (CDC) dated 11/20/20 which indicated personal protective equipment (PPE) to include a gown, gloves, face mask, and eyewear were to be worn when in resident care areas for new admission who under quarantine resident with an unknown COVID-19 status reside for 3 of 3 staff observed on the new admission quarantine unit and prevent a contracted phlebotomist from wearing gloves in the hallway when she was observed at the central nurses station for 1 of 1 contracted staff observed in a common area who were observed for infection control practices.

The Administrator was interviewed on 07/15/22 at 11:19 AM. The Administrator stated he had been at the facility for 2 days and was getting to meet the residents and staff. He stated that the facility's Quality Assurance committee met monthly and included the Administrator, Director of Nursing, Assistance Director of Nursing, Unit Manager, Social Worker, Maintenance Director, Dietary Director, Business office Manager, Housekeeping Manager, Medical records clerk, Medical Director, and pharmacist. The Administrator stated that sometimes he had to go back to the drawing board and fix the QAPI program to identify areas of weakness so that they facility could began to repair the system. He stated if the QAPI system was broken in this facility he would reach out for assistance at getting it back on track so the team could start repairing the broken systems. He

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F 867	Continued From page 98 stated he started achieving compliance yesterday when he met with the team and told them his expectations and why compliance was important. The Administrator stated that they must prioritize the broken systems starting with quality of life and work from there.	F 867		
F 880 SS=D	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 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	F 880		8/12/22

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F 880	Continued From page 99 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. §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 observation, record review, and staff interview the facility failed to disinfect a glucometer (used to check a resident's blood	F 880	F880- Infection Prevention & Control-Glucometers	

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F 880	Continued From page 100 glucose level) after use per the manufacture's recommendations which resulted in the potential for cross contamination for 2 of 2 residents (Resident #39 and Resident 25). The findings included: Review of facility policy titled "Glucometer Disinfection" revised 10/29/20 read in part; the glucometer should be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective again HIV (Human Immunodeficiency Virus), Hepatitis C and Hepatitis B virus. A continuous observation was made on 07/12/22 at 4:52 PM to 5:23 PM. Nurse #3 entered Resident #39's room prepared to check his blood glucose level. She cleaned Resident #39's right second fingertip with an alcohol swab and then used a lancet device to prick the end of the finger to obtain a blood sample. Nurse #3 then placed a drop of blood onto the testing strip that had been inserted into the glucometer. Nurse #3 disposed of the trash removed, her gloves and exited Resident #39's room. She proceeded back to the medication cart where she performed hand hygiene and opened the top draw of the cart and obtained an alcohol swab and proceeded to wipe the glucometer off for less then 5 seconds and laid the glucometer on top of the medication cart. Nurse #3 again entered Resident #39's room and administered his prescribed dose of insulin and again returned to the medication cart and performed hand hygiene. Nurse #3 then entered Resident #25's room prepared to check his blood glucose level with the same glucometer she had previously used and cleaned with an alcohol	F 880	Root Cause Analysis: On 8/8/2022, the facility□s QAPI Committee including the Medical Director, Administrator, Director of Nursing, Social Worker, SDC/Infection Preventionist, Maintenance Director, Housekeeping Director, Activities Director, Rehab Director, Dietary Director, Central Supply Clerk, and BOM attended an Ad Hoc QAPI meeting to discuss survey findings for F-880 and to determine root causes of deficient infection control practices utilizing the Five Whys Tool. The Committee determined that the root causes were: 1) Nurse did not receive proper training on the facility□s Glucometer Disinfection Policy, and, 2) Central Supply Clerk did not receive sufficient education on stocking med carts with approved healthcare disinfectant wipes during orientation. 1) On 7-14-2022, Nurse #3 was observed by state surveyor cleaning a glucometer with an alcohol wipe. According to the facility Glucometer Disinfection Policy, the glucometer should have been cleaned with an approved healthcare disinfectant wipe. The Director of Nursing observed that 3 of 4 medication carts had bleach wipes on them, but they were not the approved healthcare grade disinfectant wipes required by policy. The Director of Nursing provided education to Nurse #3, to the Central Supply Clerk, and to all licensed nurses in the facility at the time on the facility□s Glucometer Disinfection Policy including instruction on using only	

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F 880	Continued From page 101 swab. She cleaned Resident #25's right second fingertip with an alcohol swab and then used a lancet device to prick the end of the finger to obtain a blood sample. Nurse #3 then placed a drop of blood onto the testing strip that had been inserted into the glucometer. Nurse #3 threw her trash away and removed her gloves and exited Resident #25's room and returned to the medication cart where she performed hand hygiene and obtained another alcohol swab and again cleaned the glucometer for approximately 5 seconds. Nurse #3 was interviewed on 07/12/22 at 5:28 PM. Nurse #3 stated that she cleaned the glucometer between each resident use with either an alcohol swab or a disinfectant wipe. She stated that she believed that she could use either the alcohol swab or the disinfectant wipe and she just used the alcohol swab that was readily available in the top drawer or her medication cart. Nurse #3 stated that she had only been coming to the facility for 3 weeks and had not received any education on glucometers or the cleaning process since she had been at the facility. The Director of Nursing (DON) was interviewed on 07/13/22 at 12:23 PM. The DON stated that all the nurses were aware of what to use to disinfect the glucometers and to clean them between patients uses. She stated that using an alcohol swab to the disinfect the glucometer was not appropriate, and the staff should be using health grade bleach wipes to clean and disinfect the glucometers after each use. The DON stated that she had only been at the facility for about 2-3 weeks and the disinfectant wipes that were on the medication carts were not health grade. She indicated that the first thing that she needed to do	F 880	approved healthcare disinfectant wipes when cleaning glucometers. The facility had a store of approved healthcare disinfectant wipes on hand. The bleach wipes were removed from the carts, and the approved healthcare disinfectant wipes were placed on the carts as an immediate corrective action. 2) On 8/8/2022, the SDC/Infection Preventionist completed rounds to observe for proper stocking of approved healthcare disinfectant wipes on all med carts. No exceptions noted. On 8/8/2022, the SDC/Infection Preventionist completed rounds to observe nurses employing proper infection control techniques with proper supplies and equipment utilization including the use of approved healthcare disinfectant wipes during glucometer cleaning. No exceptions noted. Deficient practice potentially affects all residents who receive blood glucose testing. 3) On 8/8/2022, Regional Nurse Consultant provided education to the SDC/Infection Preventionist on maintaining an effective infection prevention and control program. Education included task of performing routine inspection of med carts to ensure they are consistently stocked with approved healthcare disinfectant wipes and process of ensuring staff maintain knowledge and competency of infection	

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F 880	Continued From page 102 was obtain the correct disinfectant wipe and then reeducate all staff. The DON stated that "alcohol swabs were not effective and should not have been used." A follow up interview was conducted with the DON on 07/15/22 at 2:12 PM. The DON stated that she had obtained health grade disinfectant wipes per their policy and placed on all medication carts for use in cleaning the glucometers. She added that education had been started and would continue until all nursing staff were appropriately trained.	F 880	prevention practices. Effective 8-12-2022, the SDC/Infection Preventionist to provide education for all licensed nurses on the facility Glucometer Disinfection Policy including the expectation that glucometers must be cleaned only with approved healthcare disinfectant wipes. All licensed nurses to receive education by August 12, 2022. Any nurses not receiving the education by this date will receive education before being allowed to work. Any newly hired facility nurses, agency nurses or Central Supply Clerks will receive education on Glucometer Disinfection Policy during orientation and prior to working on the floor. 4) The SDC/Infection Preventionist will complete monitoring of infection control practices including observations of med carts to ensure they are continuously stocked with approved healthcare disinfectant wipes. Additionally, the SDC/Infection Preventionist will perform observations of nurses performing infection control techniques with proper supplies and equipment utilization including the use of approved healthcare disinfectant wipes during glucometer cleaning. Audits will be performed for 4 staff members 5 times weekly for 4 weeks and then weekly for 8 weeks. Results of monitoring will be reported by the SDC/Infection Preventionist during QAPI meetings, and the plan will be amended as needed to maintain compliance with Infection Prevention practice and guidance.	

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F 880	Continued From page 103	F 880		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations and staff and Resident interviews the facility failed to provide a privacy curtain for 1 of 19 rooms on 300 hall reviewed for privacy. The finding included: Resident #51 was admitted to the facility on 05/16/22. The admission Minimum Data Set (MDS) assessment dated 05/24/22 revealed Resident #51 was cognitively intact. On 07/11/22 at 3:25 PM during an interview and observation of Resident #51's room, it was noted that the Resident did not have a privacy curtain between her bed (305-A) and the door. The Resident explained there had not been a privacy curtain in place since she was transferred to room 305 on 07/05/22. Resident #51 continued to explain that she required frequent brief changes	F 914	5) Completion date 8/12/2022 F914- Bedrooms Assure Full Visual Privacy 1. On 7-12-2022, the Housekeeping Director installed a privacy curtain for Resident #51 in Room 305. 2. All residents have the potential to be affected. On 7-12-2022 the Housekeeping Director completed an audit for all resident rooms to identify any additional rooms that did not have privacy curtain. No additional rooms were identified that did not have a privacy curtain. 3. On 7-15-2022 the Administrator re-educated all Department Directors on the facility policy Resident Rooms and the requirement that all residents have a privacy curtain that extends around each bed.	8/12/22

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F 914	Continued From page 104 due to incontinence and some staff knocked on her door before they entered the room and some staff did not and that there was no way to ensure her privacy without a privacy curtain. On 07/12/22 at 2:09 PM an observation of Resident #51's room revealed there thirteen hooks in the tract but there was no privacy curtain between her bed and the door. On 07/12/22 at 2:58 PM an interview was conducted with Housekeeper #1 who was assigned to 300 Hall. The Housekeeper explained that several days prior to Resident #51 being transferred into room 305, he noticed there was not a privacy curtain between the door and bed A. He continued to explain that he did not hang a privacy curtain because the tract did not have enough hooks to hang a privacy curtain, so he reported it to his supervisor. An interview was conducted with the Environmental Supervisor (EVS) on 07/12/22 at 4:59 PM who explained that she conducted random room audits every day, but she had not been in room 305 that week and was not aware of the missing privacy curtain. The EVS continued to explain that Housekeeper #1 informed her earlier that day (07/12/22) that he went to hang the privacy curtain in room 305 before Resident #51 was transferred into that room but there was not enough hooks in the tract to hang the curtain. The EVS stated she had gotten enough hooks from an empty room and hung the privacy curtain in room 305. During an interview with the Registered Nurse Consultant (RNC) and the Director of Nursing (DON) on 07/15/22 at 12:29 PM the DON	F 914	Effective 8-12-2022, the Staff Development Coordinator will educate all staff on the facility policy Resident Rooms and the requirement that all residents have a privacy curtain that extends around each bed. Newly hired staff and agency staff will receive education upon hire and prior to first shift worked. 4. The Maintenance Director will audit resident rooms for a privacy curtain with 5 resident rooms weekly x 4 weeks, 3 resident rooms weekly x 4 weeks, then 2 resident rooms weekly x 4 weeks. The results of the Resident Room Audit will be reported to the QAPI Committee monthly x 3. 5. The date of compliance is 8-12-22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 07/15/2022

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F 914	Continued From page 105 explained that room 305 should have been equipped with the privacy curtain before any resident was transferred to that room.	F 914		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to provide a resident with a call bell or an alternative communication method to call for staff assistance. This was for 1 of 5 residents reviewed (Resident #131). The finding included: Resident #131 was admitted to the facility on 07/05/22. Review of an Admission Assessment dated 07/05/22 competed by Nurse #4 indicated that Resident #131 demonstrated/verbalized understanding of the call bell. Review of a Social Services Assessment dated 07/08/22 indicated that Resident #131 was cognitively intact. An observation and interview were conducted	F 919	F919- Resident Call System 6. On 7-15-2022, the Maintenance Director installed a call bell for Resident #131. 7. All residents have the potential to be affected. On 7-15-2022 the Maintenance Director completed an audit for all resident rooms to identify any additional residents that did not have a call bell. No additional residents were identified that did not have a call bell. 8. On 8-8-2022 the Administrator re-educated all Department Directors on the facility policy Call Lights: Accessibility and Timely Response and the requirement that all residents have a call bell within reach. 9. Effective 8-12-2022, the Staff	8/12/22

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F 919	Continued From page 106 with Resident #131 on 07/11/22 at 10:32 AM. Resident #131 was resting in her bed. She had no visible call bell and the call bell station on the wall was observed to have a black plug in it with no call bell attached. When Resident #131 was asked about her call bell she stated "I have been looking for one but have not found one. If I need assistance, I usually walk down the hallway and try to get some help but that is hard because my family has not brought my shoes yet". An observation of Resident #131 was made on 07/12/22 at 11:08 AM. Resident #131 was ambulating back from the bathroom and sat down on the side of her bed. She did not have a call bell available to her and the call bell station on the wall continued to have a black plug in it with no call bell attached. An observation of Resident #131 was made on 07/13/22 at 8:45 AM. Again Resident #131 was ambulating back from the bathroom and sat down on the side of her bed. She did not have a call bell available to her and the call bell station on the wall continued to have a black plug in it with no call bell attached. An observation of Resident #131 was made on 07/14/22 at 9:06 AM. Resident #131 was sitting on the side of her bed and had just finished her breakfast. She did not have a call bell available to her and the call bell station on the wall continued to have a black plug in it with no call bell attached. An interview was conducted with Nurse Aide (NA) #1 on 07/14/22 at 2:04 PM. NA #1 confirmed that she cared for Resident #131 on 07/11/22 and 07/12/22. She stated that Resident #131 could	F 919	Development Coordinator educated all staff on the facility policy Call Lights: Accessibility and Timely Response and the requirement that all residents have a call bell within reach. Newly hired staff and agency staff will receive education upon hire and prior to first shift worked. 10. The Housekeeping Director will audit resident rooms for Call Bells with 5 resident rooms weekly x 4 weeks, 3 resident rooms weekly x 4 weeks, then 2 resident rooms weekly x 4 weeks. The results of the Resident Call Bell Audit will be reported to the QAPI Committee monthly x 3. 11. The date of compliance is 8-12-22.	

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F 919	Continued From page 107	F 919		

easily use the call bell but could not recall if she had turned the call light on or not. She stated that the only interaction she had with Resident #131 on both days she cared for her was when she went into her room to check on her. NA #1 stated that all residents were to have a call bell and it was to be kept in their reach and she was unaware that Resident #131 did not have a call bell.

NA #2 was interviewed on 07/14/22 at 5:08 PM. NA #2 confirmed that he cared for Resident #131 on second and third shift on 07/13/22. He stated that he could not recall if Resident #131 used her call bell during that shift but stated she could use the call bell if she needed assistance. NA #2 stated that all residents were supposed to have a call bell and he was unaware that Resident #131 did not have a call bell.

Nurse #4 completed the admission assessment who indicated the resident demonstrated/verbalized understanding on the call bell.

An interview was conducted with the Maintenance Supervisor on 07/14/22 at 4:51. The Maintenance Supervisor stated that each month he made sporadic checks of rooms on each hall ensuring the call bell system functioned. He stated he would go down each hallway and go into a room and turn the call bell on and have his assistant stay in the hallway to ensure that the light came on as it was supposed to. He further indicated he did the same thing for bathroom call bells and after he completed his checks, he would log them into the electronic system for record keeping. The Maintenance Supervisor reviewed the logs and stated the last time Resident #131's room was

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F 919	Continued From page 108	F 919		

checked for call bell function ability was April 2022. He went to observe Resident #131's room and stated that he was unaware that they were getting a new resident in that room, or he would have made sure there was a call bell available. The Maintenance Stated stated that when he was made aware of new admissions during the morning meeting he always went to the room and ensured the television worked and remote had batteries, the bed worked, and the call bell functioned.

The Director of Nursing (DON) was interviewed on 07/15/22 at 12:46 PM. The DON stated the unit where Resident #131 resided used to be the quarantine unit and those rooms were single occupancy rooms at that time. When the quarantine unit moved, and that unit became the new admission unit unfortunately that room got missed when the rooms got set back up for double occupancy and the call bell never got replaced in Resident #131's room. She explained that she had only been at the facility for 2-3 weeks and that they discussed new admissions in the morning meeting held Monday through Friday and the Maintenance Supervisor was responsible for ensuring the room was ready for the new admission.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to complete a comprehensive discharge summary that included a recapitulation of stay for 1 of 1 resident reviewed for discharge. (Resident #21). The Findings included: Resident #21 was initially admitted to the facility on 06/12/18. Review of Resident #21's quarterly Minimum Data Set assessment dated 04/24/22 revealed Resident #21 was severely impaired cognitively. Review of Resident #21's electronic medical record revealed a discharge summary dated 05/06/22 that did not include a recapitulation of stay. Review of Resident #21's electronic medical record revealed he was discharged from the facility on 05/06/22 to another facility with a secured/locked unit. An attempted phone interview was conducted with Resident #21's representative on 07/15/22 at 3:42 PM. They were unable to be reached. During an interview with Social Worker #2 on 07/14/22 at 2:16 PM, she reported she no longer worked at the facility but was present at the time of the discharge. She reported she was unsure who was responsible for ensuring the discharge summary was completed but reported she completed her section like she was supposed to.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 661	Continued From Page 1

During an interview with the Director of Nursing on 07/15/22 at 12:40 PM, she reported she was not working in the facility at the time of this discharge but that discharge summaries should be completed fully. She reported she was unsure why the discharge summary was incomplete

During an interview with the Administrator on 07/15/22 at 3:17 PM, he indicated it was expected that discharge summaries that included a recapitulation be completed and provided to residents or resident representatives at the time of discharge.