STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency	E 004		10/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/13/2022

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E 004	Continued From page 1 Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual updates and review of the facility's Emergency Preparedness Plan. This failure had the potential to affect all staff and residents. Findings included: A review of the facility's Emergency Preparedness Plan (EPP) occurred on 9/16/2022 at 2:44 p.m. with the Nursing Home Administrator (NHA). It was discovered the emergency plan had not been updated in the last twelve months and was last updated on 4/10/2020. The emergency contact information of the facility was not updated. In an interview with the NHA on 9/16/2022 at 2:44 p.m., she stated she didn't realize the EPP had not been reviewed with administrative staff and the Quality Assurance Performance Improvement (QAPI) team in the last twelve months and stated the emergency contact information was not up to date due to resignations in the facility. The NHA stated the EPP manual should be reviewed and updated annually with current emergency contact information.	E 004	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. E0004 Develop EP Plan, Review and Update Annually CFR(s): 483.73 (a) A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. On 09/19/2022, the facility Administrator reviewed and updated the Emergency Preparedness Plan for the facility. This included updating the emergency contact information for the facility and placing that information in the Emergency Preparedness Plan. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:	

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E 004	Continued From page 2	E 004	1. On 09/19/2022, the Administrator completed an audit of the facility Quality Assurance and Performance Improvement (QAPI) minutes for the last 12 months to determine if the facility had reviewed the Emergency Preparedness Plan. A QAPI meeting was held with the facility Interdisciplinary Team (IDT) on 09/19/2022. 2. On 9/19/2022, the Regional Director of Operations educated the Nursing Home Administrator (NHA) on the Emergency Preparedness Plan including necessity of annual reviews and updates and updating the emergency contact information. The NHA and/or designee will educate the IDT on the importance of reviewing and updating the Emergency Preparedness Plan at least annually and updating the emergency contact list. All newly hired administrative staff will receive education on the Emergency Preparedness Plan. Newly hired staff members will be informed about updates and changes to the EPP during orientation, Stand up meetings and doing QAPI meetings. C. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The facility BOM and/or designee will audit the Emergency Preparedness Plan weekly for four (4) weeks, then monthly for three (3) months using the Emergency Preparedness Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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E 004	Continued From page 3	E 004	D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. The NHA and/or designee will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. The facility alleges compliance on 10/14/2022.	
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 9/12/2022 to 9/16/2022. Event ID# X38E11. The following intakes were investigated: NC00189368, NC00190866, NC00191907, NC00190911, NC00191652, NC00191848 and NC00192917. Six of the 40 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		10/14/22

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F 637	Continued From page 4 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS) within the 14-day time frame for 2 of 33 residents reviewed for resident assessments (Resident #19, Resident #75). Findings Included: Resident #19 was readmitted to the facility on 8/23/2022. On 9/12/2022, a SCSA MDS dated 8/29/2022 indicated it was "in progress" and the care areas and care plan decisions were incomplete. On 9/14/2022 at 9:29 a.m. in an interview with the MDS Corporate Nurse, she stated the facility did not have a MDS nurse, and she filled in at times to complete resident MDS assessments until the facility hired someone to fill the role. She stated she realized MDS assessments were not being completed in the time frames. On 9/16/2022 at 2:28 p.m. in an interview with the Administrator, she stated Resident #19's significant change MDS should had been completed in the designated time frame. 2. Resident #75 was admitted to the facility on 9/8/2017. Review of a hospice visit note dated 7/12/2022 showed Resident #75 was discharged and indicated the reason for discharge as "no longer terminally ill."	F 637	F637 Comprehensive Assessment 1. A significant change in status assessment (SCSA) was completed as required for resident #19 for admission to hospice and #75 for discharge to Hospice Services on 9/15/22 by the Regional Minimum Data Set (MDS) Coordinator. 2. The Regional Director of Clinical Services audited the Minimum Data Set (MDS) in progress on October 12, 2022 to ensure a significant change in status assessment was completed for any resident that required an admission or discharge to Hospice services was in compliance. 3. Effective October 13, 2022 the Regional Director of Clinical Services educated the facility's interim MDS nurse on completion of a significant change in status assessment for any resident that requires admission or discharge to Hospice services upon hire. 4. The Director of Nursing or Regional Minimum Data Set (MDS) Coordinator will audit 10% of weekly Minimum Data Set (MDS) for significant change in status assessment timely completion of admission or discharge to Hospice Services prior to transmission for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Date of Compliance October 14, 2022	

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F 637	Continued From page 5 A physician order initiated on 7/13/2022 read in part "resident was discharged from hospice on 7/12/2022." Review of Resident #75's electronic medical records revealed no Significant Change MDS was completed for the 7/12/2022 hospice discharge. An interview with the Regional MDS Coordinator was conducted on 9/14/2022 at 9:05 A.M. She indicated it was the responsibility of the individual who coded the MDS to ensure accuracy of the resident information submitted and to complete the information in the required time frame. The Regional MDS Coordinator further indicated the facility had MDS's that were not completed within the required timeframe. Director of Nursing and the Regional Nurse Consultant was conducted on 9/14/2022 at 9:35 A.M. During the interview both staff indicated they expected the MDS to be completed within the correct timeframe. An interview with the Administrator was conducted on 9/16/2022 at 2:28 P.M. During the interview, the Administrator indicated MDS's needed to be completed with the designated time.	F 637	F 641 Accuracy of Assessments 1. Resident #138 Minimum Data Set (MDS) was unable to be modified by the Minimum Data Set (MDS) Coordinator to reflect his mental status and mood for his admission assessment dated 8/19/22. Resident #40 Minimum Data Set was modified by the Regional Minimum Data Set (MDS) Coordinator to reflect accurate coding on 10/11/22. Resident #7 Minimum Data Set was modified 9/14/22 by the Regional Minimum Data Set (MDS) Coordinator to reflect accurate coding of residents' weights. Resident #75 Minimum Data Set was modified 9/5/22 by the Regional MDS Coordinator to reflect accurate coding of hospice services. 2. The VP of Clinical Reimbursement completed audits of Minimum Data Set (MDS) completed in the last 3 months to ensure mental status and mood (MDS section C), insulin injections (MDS section N0350A), weights (MDS K0200B) and hospice services (MDS Section O0100K) is accurately coded on 10/10/22. Any negative findings were modified on 10/10/22. 3. On October 13, 2022 the Regional Director of Clinical Services educated the facility's interim Minimum Data Set (MDS) nurse on the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) Sections C, N0350A, K0200B, O0100K upon hire. 4. The Director of Nursing or Regional Minimum Data Set (MDS) Coordinator will	

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F 637	Continued From page 6	F 637	audit 10% of Minimum Data Set (MDS) weekly for section C, N0350A, K0200B and O0100K accuracy prior to transmission for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Date of Compliance: October 14, 2022 F 656 Comprehensive Care Plans 1. Comprehensive individualized care plans were developed for Resident #32 regarding ADL's and presence of a catheter and Resident #29 regarding ADL's on 10/12/22 by the Regional Clinical Nurse Consultant. 2. All current residents admitted in the past 30 days were audited by the VP of Clinical Reimbursement to ensure individualized care plans for ADLs and catheters (if applicable) were developed. 3. On October 13, 2022 the Regional Director of Clinical Services educated the interim Minimum Data Services (MDS) Coordinator on completing comprehensive individualized care plans for residents on or before the 21st day of stay and to update the care plan quarterly with any changes. This education will be part of the new hire orientation. 4. The Director of Nursing or Regional MDS Coordinator will audit 10% of comprehensive care plans to make sure	

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F 637	Continued From page 7	F 637	they are individualized to included ADL's and catheters according to compliance for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Date of Compliance: October 14, 2022 F 657 1. On October 12, 2022, the Interdisciplinary Team (IDT) held a care conference with Resident #29 and made revisions to the plan of care as determined by the resident and IDT. Resident #29 will continue to be invited to attend care conferences based on the comprehensive Minimum Data Set (MDS) schedule and with changes in condition. Resident #137 care plan was updated 9/14/22 by the Regional MDS Coordinator to include the use of oxygen 2. Effective 10/12/22, the Regional Minimum Data Set (MDS) Coordinator completed an audit of care plan conference meetings based upon the MDS assessment dates to identify those due or late. The Interdisciplinary Team, consisting of the Director of Nursing or Unit Manger, Activity Director, Business Office Manager, Director of Rehabilitation, and Director of Dietary Services participated in care plan conferences with invitation to the resident and resident representative on all identified residents. Care conferences will be scheduled moving forward per the MDS assessment dates.	

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F 637	Continued From page 8	F 637	3. The Interdisciplinary Team (IDT), consisting of the Administrator, Director of Nursing, Unit Mangers, Activity Director, Business Office Manager, Director of Rehabilitation, and Director of Dietary Services were educated by the Regional Director of Clinical Services on 10/12/2022 on the care plan meeting policy and process. Effective 10/13/22, the Director of Nursing will take responsibility for providing the care plan schedule to the interdisciplinary team and the Admission Director notifying the responsible representative until a MDS coordinator is hired. Then the MDS nurse will provide the IDT with the MDS dates and corresponding care conference schedule and the Social Worker will send invitations to the resident and resident representative. Newly hired IDT members will receive education upon hire as a part of the orientation process. 4. The Minimum Data Set Coordinator will complete audits 3 day per week for 4 weeks, and the weekly for 8 weeks on completion of care plan conferences meetings with IDT and resident/resident representative participation per the MDS assessment date schedule. The Director of Nursing and the Administrator will review the audits completed by Interdisciplinary Team once per week for 12 weeks for additional oversight. The Administrator will discuss the audit results during the monthly Quality Assurance Performance Improvement Committee	

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F 637	Continued From page 9	F 637	Meeting for 3 months to ensure compliance and make changes to the plan as necessary. Date of compliance October 14, 2022	
F 641 SS=B	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 complete accurate Minimum Data Set (MDS) assessments in the areas of mental status and mood assessment (Resident #138), medications (Resident #40), weight (Resident #7), and hospice (Resident #75) for for 4 of 25 residents with MDS assessments reviewed. Findings included: 1. Resident #138 was admitted to the facility on 8/15/2022. Nursing documentation dated 8/15/2022 revealed Resident #138 was alert and oriented to person, place, time and events. The admission Minimum Data Set (MDS) assessment dated 8/19/2022 indicated Resident #138's mental status and mood should have been assessed. A review of the admission MDS revealed Resident #138's mental status and mood assessment had not been assessed. Nursing documentation dated 8/15/2022 revealed Resident #138 was alert and oriented to person,	F 641	F 641 Accuracy of Assessments 1. Resident #138 Minimum Data Set (MDS) was unable to be modified by the Minimum Data Set (MDS) Coordinator to reflect his mental status and mood for his admission assessment dated 8/19/22. Resident #40 Minimum Data Set was modified by the Regional Minimum Data Set (MDS) Coordinator to reflect accurate coding on 10/11/22. Resident #7 Minimum Data Set was modified 9/14/22 by the Regional Minimum Data Set (MDS) Coordinator to reflect accurate coding of residents' weights. Resident #75 Minimum Data Set was modified 9/5/22 by the Regional MDS Coordinator to reflect accurate coding of hospice services. 2. The VP of Clinical Reimbursement completed audits of Minimum Data Set (MDS) completed in the last 3 months to ensure mental status and mood (MDS section C), insulin injections (MDS section N0350A), weights (MDS K0200B) and hospice services (MDS Section O0100K) is accurately coded on 10/10/22. Any	10/14/22

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F 641	Continued From page 10 place, time and events. On 9/16/2022, the MDS Corporate Nurse was unavailable for interview. In an interview with the Director of Nursing on 9/16/2022 at 1:47 p.m., she stated Resident #138 was alert and oriented and was able to answer questions for the mental status and mood assessment on the admission MDS. In an interview with the Administrator on 9/16/2022 at 1:53 p.m., she stated mental status and mood assessments for Resident #138 should had been assessed, and MDS assessments should be accurate. 2. Resident #40 was admitted to the facility on 11/29/2016. Physician orders dated 5/5/2022 revealed Resident #40 was ordered Dulaglutide, a glucose -lowering agent that is not a form of insulin, 0.75 milligrams (mg) per 0.5 milliliter 1.5mg subcutaneously once a day on Mondays for Diabetes Mellitus. Dulaglutide The quarterly Minimum Data Set (MDS) assessment dated 7/5/2022 indicated Resident #40 was ordered insulin and had received an insulin injection once. On 9/16/2022, the MDS Corporate Nurse was unavailable for interview. On 9/16/2022 at 1:35 p.m. in an interview with the Director of Nursing, she stated Dulaglutide was not an insulin, and Resident #40's quarterly MDS	F 641	negative findings were modified on 10/10/22. 3. On October 13, 2022 the Regional Director of Clinical Services educated the facility's interim Minimum Data Set (MDS) nurse on the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) Sections C, N0350A, K0200B, O0100K upon hire. 4. The Director of Nursing or Regional Minimum Data Set (MDS) Coordinator will audit 10% of Minimum Data Set (MDS) weekly for section C, N0350A, K0200B and O0100K accuracy prior to transmission for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Date of Compliance: October 14, 2022	

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F 641	Continued From page 11	F 641		

should not had been coded for receiving insulin.

On 9/16/2022 at 2:28 p.m. in an interview with the Administrator, she stated Resident #40's quarterly care plan should have been completed accurately.

3. Resident #7 was admitted to the facility on 2/28/2022.

Resident #7's weights were observed documented in the electronic medical record (EMR) and reviewed. On 5/20/2022 his weight was 105.2 pounds. There was indication as to how the weight was collected. On 6/11/2022 his weight was noted as 109.0 pounds collected by a mechanical lift.

Resident #7's quarterly MDS dated 6/7/2022 indicated Resident #7 weighed 109 pounds.

The Dietary Manager was unavailable for an interview.

An interview with the Regional MDS Coordinator was conducted on 9/14/2022 at 9:05 A.M. She indicated it was the responsibility of the Dietary Manager to review and complete the weight section on the MDS. During the interview, the Regional MDS Coordinator reviewed Resident #7's chart. She confirmed the weight of 105.2 pounds collected on 5/20/2022 should be the weighted entered on the MDS, as the weight of 109.0 pounds was collected on 6/11/2022 after

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ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

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the ARD date of 6/7/2022.

An interview with the Director of Nursing and the Regional Nurse Consultant was conducted on 9/14/2022 at 9:35 A.M. During the interview both staff indicated they expected the MDS to be coded accurately.

4. Resident #75 was admitted to the facility on 9/8/2017.

Review of a hospice visit note dated 7/12/2022 showed Resident #75 was discharged and indicated the reason for discharge as "no longer terminally ill."

A physician order initiated on 7/13/2022 read in part "resident was discharged from hospice on 7/12/2022."

Resident #75's quarterly MDS dated 8/11/2022 indicated Resident #75 received hospice care.

An interview with the Regional MDS Coordinator was conducted on 9/14/2022 at 9:05 A.M. She indicated it was the responsibility of the individual who coded the MDS to ensure accuracy of the resident information submitted. During the interview, the Regional MDS Coordinator reviewed Resident #75's chart. She confirmed Resident #75 had been removed from hospice care on 7/12/2022 and indicated the resident should not have been coded as receiving hospice on the MDS dated 8/11/2022. The Regional MDS Coordinator indicated she was unsure why Resident #75's discharge from hospice was overlooked during the MDS review.

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F 641	Continued From page 13 An interview with the Director of Nursing and the Regional Nurse Consultant was conducted on 9/14/2022 at 9:35 A.M. During the interview both staff indicated they expected the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		10/14/22

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F 656	Continued From page 14 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop and implement an individualized person-centered care plan for 2 of 24 residents reviewed for activities of daily living and indwelling catheter. (Resident #32 and Resident #29). Findings included: 1. Resident #32 was admitted to the facility on 4/12/22 with diagnoses including urinary retention and dementia. The admission Minimum Data Set (MDS) dated 4/18/22 for Resident #32 revealed he needed extensive assistance with transfers and toilet use. He needed limited assistance with bed mobility and supervision with eating. The MDS revealed Resident #32 had an indwelling catheter. A review of the care plans developed for Resident #32 revealed no care plans with goals and interventions were developed for activities of daily living and indwelling catheter. An interview was conducted with the MDS	F 656	F 656 Comprehensive Care Plans (Corrected approved ePOC) 1. Comprehensive individualized care plans were developed for Resident #32 regarding ADL's and presence of a catheter and Resident #29 regarding ADL's on 10/12/22 by the Regional Clinical Nurse Consultant. 2. All current residents admitted in the past 30 days were audited by the VP of Clinical Reimbursement to ensure individualized care plans for ADLs and catheters (if applicable) were developed. 3. On October 13, 2022 the Regional Director of Clinical Services educated the interim Minimum Data Services (MDS) Coordinator on completing comprehensive individualized care plans for residents on or before the 21st day of stay and to update the care plan quarterly with any changes. This education will be part of the new hire orientation.	

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F 656	Continued From page 15 Corporate Nurse on 9/14/22 at 9:29 AM, and she stated the facility did not have a Social Worker or a MDS Nurse. She stated she was filling in from time to time and completing the MDS assessments and doing the care plans until someone was hired to fill both roles. She stated she realized care plans and MDS assessments were not up to date. During a second interview with the MDS Corporate Nurse on 9/14/22 at 2:48 PM, she stated a Performance Improvement Plan (PIP) had been initiated on 9/1/22 for care plan improvement. The PIP was in process and was not completed prior to the survey. On 9/16/22 at 2:25 PM an interview was conducted with the Director of Nursing and the Regional Nurse Consultant. Both stated their expectations were for care plans to be developed and submitted on time. The Regional Nurse consultant stated they were aware the care plans were falling behind. 2. Resident #29 was admitted the facility on 6/20/2022, and diagnoses included generalized muscle weakness. Resident #29's care plan dated 6/23/2022 included two focus areas: nutrition and an infection of the skin. There were no focus areas including activities of daily living (ADLs) on	F 656	4. The Director of Nursing or Regional MDS Coordinator will audit 10% of comprehensive care plans to make sure they are individualized to included ADL's and catheters according to compliance weekly for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Date of Compliance: October 14, 2022	

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F 656	Continued From page 16 Resident #29's care plan. The admission Minimum Data Set (MDS) dated 6/29/2022 indicated Resident #29 was cognitively intact and required extensive assistance with dressing, toileting, bed mobility, and personal hygiene and total assistance with bathing and transfers. The Care Area Assessment (CAA) on the MDS triggered the following care areas and indicated were addressed on Resident #29's care plan: activities of daily living function, urinary incontinence, visual function, risk for falls, risk for pressure ulcers, and use of psychotropic drugs. On 9/14/2022 at 9:29 a.m. in an interview with the MDS Corporate Nurse, she stated the facility did not have a MDS nurse and she was filed in at times to complete resident MDS and care plans until the facility hired someone to fill the roles. She stated she realized care plans were not being kept current. On 9/16/2022 at 1:56 p.m. in an interview with the Director of Nursing, she stated Resident #29's care plan dated 6/23/2022 was not a comprehensive care plan, and the MDS nurse should have completed a comprehensive care plan for Resident #29 to include a plan of care for ADLs. On 9/16/2022 at 2:28 p.m. in an interview with the Administrator, she stated a comprehensive care plan should had been completed for Resident #29.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		10/14/22

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F 657	Continued From page 17 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to conduct a care plan meeting for 1 of 2 residents (Resident # 29) reviewed for care planning meeting and failed to revise the care plan for 1 of 1 resident observed using oxygen by nasal cannual (Resident #137) reviewed for the use of oxygen. Findings included: 1. Resident #29 was admitted to the facility on	F 657	F 657 1. On October 12, 2022, the Interdisciplinary Team (IDT) held a care conference with Resident #29 and made revisions to the plan of care as determined by the resident and IDT. Resident #29 will continue to be invited to attend care conferences based on the comprehensive Minimum Data Set (MDS) schedule and with changes in condition. Resident #137 care plan was updated	

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F 657	Continued From page 18 6/22/2022, and diagnoses included Diabetes Mellitus, anxiety disorder and major depressive disorder. The care plan dated 6/23/2022 for Resident #29 included two focuses: nutritional risk and skin infection. The admission Minimum Data Set (MDS) assessment dated 6/29/2022 indicated Resident #29 was cognitively intact, required assistance with all activities of daily living and received insulin antianxiety and antidepression medications. There was no documentation of a care plan meeting in Resident #29's electronic medical record. On 9/12/2022 at 3:15 p.m. in an interview with Resident #29, she stated the facility had not conducted a care plan meeting with her, and the facility had not informed her of a plan of care. On 9/16/2022 at 1:56 p.m. in an interview with the Director of Nursing, she stated she was responsible for scheduling the care plan meetings with the interdisciplinary team members and residents, and a care plan meeting should have occurred within seventy-two hours of admission. She stated she was unable to recall having a care plan meeting with Resident #29. 2. Resident #137 was re-admitted to the facility on 7/14/2022, and diagnoses included anemia. Resident #137's care plan dated 7/15/22 and last updated 9/5/2022 included a focus for	F 657	9/14/22 by the Regional MDS Coordinator to include the use of oxygen 2. Effective 10/12/22, the Regional Minimum Data Set (MDS) Coordinator completed an audit of care plan conference meetings based upon the MDS assessment dates to identify those due or late. The Interdisciplinary Team, consisting of the Director of Nursing or Unit Manger, Activity Director, Business Office Manager, Director of Rehabilitation, and Director of Dietary Services participated in care plan conferences with invitation to the resident and resident representative on all identified residents. Care conferences will be scheduled moving forward per the MDS assessment dates. 3. The Interdisciplinary Team (IDT), consisting of the Administrator, Director of Nursing, Unit Mangers, Activity Director, Business Office Manager, Director of Rehabilitation, and Director of Dietary Services were educated by the Regional Director of Clinical Services on 10/12/2022 on the care plan meeting policy and process. Effective 10/13/22, the Director of Nursing will take responsibility for providing the care plan schedule to the interdisciplinary team and the Admission Director notifying the responsible representative until a MDS coordinator is hired. Then the MDS nurse will provide the IDT with the MDS dates and corresponding care conference schedule and the Social Worker will send invitations to the resident and resident	

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F 657	Continued From page 19 complications related to anemia, and there was no focus or interventions includes for the use of oxygen. The admission Minimum Data Set (MDS) assessment dated 7/18/2022 indicated Resident #137 was cognitively intact and was not experiencing shortness of breath or receiving oxygen. Nursing documentation dated 8/23/2022 revealed when Resident #137 developed shortness of breath, oxygen was applied. On 9/11/2022, nursing documentation revealed Resident #137 continued to use oxygen at 2 liters per minute via nasal cannula. On 9/12/2022 at 11:10 a.m., Resident #137 was observed lying in the bed receiving humidified oxygen at 2 liters per minute via nasal cannula. On 9/14/2022 at 9:29 a.m. in an interview with the MDS Corporate Nurse, she stated the facility did not have a MDS nurse and she was filed in at times to complete resident MDS and care plans until the facility hired someone to fill the roles. She stated she realized care plans were not being kept current. On 9/14/2022 at 3:17 p.m. in an interview with the Director of Nursing, she stated care plans were updated when nursing staff alerted the MDS nurse or herself of changes in the residents and stated Resident #137's care plan should had been updated to include the use of oxygen.	F 657	representative. Newly hired IDT members will receive education upon hire as a part of the orientation process. 4. The Minimum Data Set Coordinator will complete audits 3 day per week for 4 weeks, and the weekly for 8 weeks on completion of care plan conferences meetings with IDT and resident/resident representative participation per the MDS assessment date schedule. The Director of Nursing and the Administrator will review the audits completed by Interdisciplinary Team once per week for 12 weeks for additional oversight. The Administrator will discuss the audit results during the monthly Quality Assurance Performance Improvement Committee Meeting for 3 months to ensure compliance and make changes to the plan as necessary. Date of compliance October 14, 2022	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/14/22

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F 689	Continued From page 20 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to (1) complete smoking assessments on residents observed unsupervised smoking in the facility's designated smoking area (Residents #65, #70, #80, # 81), (2) failed to supervise a resident who required supervision while smoking (Resident #69) and (3) failed to secure smoking materials for a resident (Resident #81) for 5 of 5 residents reviewed for smoking. A review of the facility's provided list of smokers on day one of the survey, 09/12/22, revealed Resident #65, Resident #80, and Resident #81 were not on the list. A revised smoker's list was submitted by the facility on 09/14/2022, day 3 of the survey, which included Resident #65, Resident #80. 1. Resident #65 was admitted to the facility on 07/27/22 with diagnoses which included congestive heart failure and nicotine dependence. A review of Resident #65's admission Minimum Data Set (MDS) dated 08/01/22 revealed he was cognitively intact and coded as a non-tobacco user.	F 689	F689 Resident Affected: Residents #65, #70, #80 and #81 had smoking assessments completed prior to the survey exit. The facility is unable to retro-correct the lack of supervision concern identified on 9/14/2022 for Resident #69. Smoking materials for resident #81 were secured by the facility for the residents' future use prior to the survey exit. Residents with Potential to be Affected: Nursing Leadership to include the Director of Nursing, Unit Managers and Staff Development Coordinator is conducting a 100% audit of all residents to ensure the facility is aware of all residents that smoke. Those residents identified will have an updated smoking assessment completed to determine their level of smoking safely. Residents care plans will be updated accordingly. The smoking policy was reviewed with all the identified residents who smoke on 10/11/22 by the	

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F 689	Continued From page 21 Resident # 65's record review revealed there was no safe smoker's assessment completed. Further record review of Resident #65's care plan dated 08/22/22 revealed he was not care planned for smoking. Observation on 09/13/22 at 1:43 pm revealed Resident #65 was in the facility's designated smoking area. Continuous observation revealed Resident #65 was smoking without supervision by a staff member. Interview with Resident #65 on 09/13/22 at 1:44 pm revealed he smoked every day and had been smoking since his admission on 07/27/22. Resident #65 also stated he kept his smoking materials in his room or on his person. Resident #65 stated the smoking area was unlocked and he was able to smoke whenever he decided to do so. Resident #65 continued by stating there was usually not a staff member present when he and other residents smoked. An interview with the Director of Nursing, (DON) on 09/14/22 at 11:43 AM revealed she wasn't sure when Resident #65 started smoking. The DON also looked up Resident #65's medical chart during this interview and stated Resident #65 was not care planned for smoking and a safe smoker assessment had not been completed. The DON stated Resident #65 should have been assessed for smoking prior to being allowed to smoke. 2. Resident #69 was admitted to the facility on 10/26/21 with diagnoses which included muscle weakness. A review of quarterly Minimum Data Set (MDS)	F 689	Administrator to include the smoking schedule with staff assignments. Any concerns will be addressed by the Administrator or Director of Nursing. All smoking materials will be removed from residents based on their smoking assessment and secured in the designated area by the assigned smoking monitor. The Admission's Coordinator will review the smoking policy with all newly admitted residents. Systematic Changes: Effective October 12, 2022 all licensed nurses and CNAs were educated by the Staff Development Coordinator, Director of Nursing or Unit Manger on completing a smoking assessment upon admission, quarterly and with a significant change in condition; the smoking policy to include supervision of those residents identified based on their smoking assessment and securing smoking materials. The Regional Director of Clinical Services educated the nurse leaders (Director of Nursing and Unit Managers) on implementing smoking care plans for residents identified as smokers. Newly hired licensed nurses/ CNA's and agency nurses/CNA's will receive education prior to working or as part of the new hire orientation. Monitoring:	

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F 689	Continued From page 22 dated 08/04/22 revealed he had mild cognitive impairment, and the smoking section of the assessment was left blank. Resident #69's record review revealed he required supervision while smoking per safe smoker's assessment completed on 7/27/22. Further record review of Resident #69's care plan dated 08/25/22 revealed he would not smoke without supervision and would not suffer injury from unsafe smoking practices through the next review date of 11/10/22. Observation on 09/14/22 at 09:57 am revealed Resident #69 was in the facility's designated smoking area. Continuous observation revealed Resident #69 removed a lighter from his pants pocket, removed a cigarette from a pack of cigarettes found in his shirt pocket and lit his cigarette. Resident #69 began smoking the cigarette. There was not a staff member present for this observation. Interview with Resident #69 on 09/14/222 at 9:59 am revealed he smoked every day and had been a smoker at the facility since he was admitted in 2021. Resident #69 also stated he could come out and smoke whenever he wanted to and most of the time there was not a staff member present. Interview with the Director of Nursing (DON) on 09/14/22 at 11:43 AM revealed she looked up Resident #69's medical chart and stated Resident #69 was assessed on 07/27/22 as a supervised smoker and his care plan reflected him as a supervised smoker. The DON added Resident #69 should have been supervised by staff when he was observed outside smoking on 09/14/22 at 9:57 am.	F 689	Using a facility created audit tool, the Director of Nursing, Unit Manager or Staff Development Coordinator will complete the audit to ensure the residents smokers assessments are up to date, smokers care plans are up to date and the smoking materials are secured. This audit will be completed three (3) times a week x 4 weeks then once (1) a week x 8 weeks to ensure compliance. The Department Heads to include the Director of Nursing, Unit Managers, Staff Development Coordinator, Business Office Manager, Social Worker, Activities Director, Maintenance Director, Medical Record Coordinator and Housekeeper Director will audit through observation current facility smokers three (3) times a week x 4 weeks, then two (2) times a week x 4 weeks then weekly for 4 weeks then ongoing as needed to ensure they are receiving the appropriate supervision based on their current Smoking Assessment. The Administrator or Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance. Completion Date: October 14, 2022	

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F 689	Continued From page 23	F 689		

3. Resident #70 was admitted to the facility on 01/28/22 with diagnoses which included tobacco use.

A review of the quarterly Minimum Data Set (MDS) dated 08/04/2022 revealed he had moderate cognitive impairment and the smoking section of the assessment was left blank.

Resident #70's record review revealed there was no safe smoker's assessment completed. Further record review of Resident #70's care plan dated 08/25/22 revealed he would not smoke without supervision through the review date of 11/10/22. Further record review of Resident #70's care plan dated 08/25/22 revealed he would not smoke without supervision and would not suffer injury from unsafe smoking practices through the next review date of 11/10/22.

Observation on 09/14/22 at 09:57 am revealed Resident #70 was in the facility's designated smoking area. Continuous observation revealed Resident #70 had a cigarette lighter in his right hand and removed a single cigarette from his shirt pocket and lit the cigarette. Resident #70 began smoking the cigarette. There was not a staff member present for this observation.

Interview with Resident #70 on 09/14/22 at 10:02 am revealed he had been smoking for a long time at the facility every day. Resident #70 stated he usually came outside to the designated smoking area along with other residents to smoke each day. Resident #70 further stated there was hardly ever a staff member present.

Interview with the Director of Nursing (DON) on

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09/14/22 11:43 AM revealed she looked up Resident #70's medical chart and stated there was not a safe smoker's assessment completed and Resident #70's care plan indicated he would not smoke without supervision. The DON further stated Resident #70 should have been supervised by staff when he was observed outside smoking on 09/14/22 at 9:57 am.

4. Resident #80 was admitted to the facility on 08/15/22.

A review of the admission Minimum Data Set (MDS) dated 08/19/22 revealed the section of the cognition assessment was left blank and she was coded as a non-tobacco user.

Resident #80's record review revealed there was no safe smoker's assessment completed. Further record review of Resident #80's care plan dated 08/16/22 revealed she was not care planned for smoking.
Observation on 09/14/22 at 9:57 am revealed Resident #80 was in the designated smoking area of the facility. Continued observations revealed Residents #80 was smoking a cigarette. There was not a staff member present.

Interview with Resident #80 on 08/14/2022 at 10:07 am stated she always went out to smoke without staff and the only reason some sessions this week were now being supervised was because the state surveyors were on site. Resident #80 further stated she didn't know if she was supposed to be a supervised smoker or not because she had not been assessed either way.

Interview with the Director of Nursing (DON) on 09/14/22 at 11:43 AM revealed she thought

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Resident #80 must have started smoking about a week ago because she saw Resident #80 outside (not sure of the day) smoking and she remembered thinking to herself "she didn't know" Resident #80 was a smoker. The DON also looked up Resident #80's medical record during this interview and stated Resident #80 was not care planned for smoking and a safe smoker assessment had not been completed. The DON stated Resident #80 should have been assessed for smoking prior to being allowed to smoke.

Interview with the Regional Nurse Consultant on 09/14/22 at 11:43 am revealed residents should be assessed for smoking prior to being allowed to smoke at the facility and each resident should have an up-to-date and active care plan for their individual needs and outcomes of their safe smoking assessments.

An interview with the Administrator on 09/16/22 at 3:44 pm revealed residents who are allowed to smoke, supervised or independent, should be followed by the plan of care initiated. She further stated residents should be assessed to determine if they were safe to smoke prior to engaging in smoking at the facility.

5. Resident #81 was admitted to the facility on 8/16/2022.

A Safe Smoking Screening dated 8/16/2022 indicated Resident #81 was not a current smoker and had never smoked, used smokeless tobacco or an electronic cigarette.

The admission Minimum Data Set (MDS)

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assessment dated 8/19/2022 indicated Resident #81 was severely cognitively impaired, required assistance with transfers and used tobacco.

Nursing documentation dated 9/1/2022 revealed Resident #81 returned from the smoking area and refused to stay in her room. Further, nursing documentation dated 9/9/2022 revealed Resident #81 self-propelled herself to the smoking area.

Resident #81's care plan dated 9/2/2022 included a focus for smoking, and interventions included Resident #81 required supervision while smoking.

Resident #81 was not listed on the facility's list for smokers provided on 9/12/2022 and was not listed on the revised smoker list provided on 9/14/2022.

On 9/13/2022 at 9:52 a.m. in an interview with Resident #81, she stated she was a smoker. She stated she kept her cigarettes and lighter in her room and went to smoke in the designated smoking area when she got ready unsupervised by the nursing staff.

On 9/13/2022 at 12:45 p.m., Resident #81 was observed sitting upright in her standardized wheelchair holding a cigarette in her right hand near the entrance of the designated smoking area. There were no staff from the facility observed in the designated smoking area. Resident #81 was observed able to control holding the cigarette while moving her right hand toward the mouth to inhale on the cigarette and was observed flipping cigarette ashes onto the ground. Containers for the ashes were located under the canopy in the designated smoking area and not near where Resident #81 was position at

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the entrance of the designated smoking area.

On 9/14/2022 at 7:00 a.m. in an interview with Nurse Aide (NA) #1, she stated Resident #81 was a safe smoker and would get herself up every morning and go outside to smoke. She stated nursing staff or the activity director kept smoking materials for the residents and nursing staff were outside with smokers most of the time when residents were smoking.

On 9/14/2022 at 4:10 p.m. in an interview with Resident #81, she stated she kept her smoking materials in her wheelchair. A pack of cigarettes and a lighter in an empty cigarette pack were observed under the wheelchair cushion.

On 9/15/2022 at 4:50 p.m. in an interview with Nurse #3, she stated when she completed the Safe Smoking Screening dated 8/16/2022 based on how Resident #81 answered the questions. She stated she had not been her caregiver since admission, and if it was discovered that Resident #81 was a smoker after her admission, another safe smoking assessment should had been conducted.

On 9/16/2022 at 8:50 p.m., Resident #81 was observed outside sitting in her wheelchair in the designated smoking area smoking a cigarette with no facility staff observed outside with Resident #81.

On 9/16/2022 at 12:44 p.m. in an interview with Nurse #4, she stated Safe Smoking Assessments were conducted on admission by the nursing staff and quarterly by the unit managers. She stated another Safe Smoking Assessment should had been completed on Resident #81 to determine if

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F 689	Continued From page 28 she was a safe smoker, a resident that did not require supervision for smoking. She stated smoking materials were not to be in the possession of Resident #81 and when staff gathered smoking materials from residents, residents would get another supply. She stated nursing supervision in the designated smoking area was based on the schedule of assigned staff in the smoking book. On 9/16/2022 at 1:29 p.m. in an interview with Director of Nursing, she stated the Facility's Smoking List was updated when residents were admitted based the initial Safe Smoking Assessment. She stated the reason Resident #81 was not on the Facility's Smoking List was because she was evaluated as a nonsmoker on admission, and Resident #81 needed an updated Safe Smoking Assessment. She stated the facility had designated smoking times with staff monitoring. She stated based on Resident #81 ' s care plan she needed to be supervised when smoking but Resident #81 was used to smoking when she wanted before admission to the facility.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		10/14/22

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F 695	Continued From page 29 Based on observations, record review, staff interviews, the facility failed to obtain a written physician's order for the use of oxygen and display cautionary signage indicating oxygen in use for 1 of 1 resident reviewed for respiratory care. (Resident #137) Findings Included: Resident #137 was admitted to the facility on 7/14/2022, and diagnoses stage 4 chronic kidney disease and anemia. The admission Minimum Data Set (MDS) assessment dated 7/18/2022 indicated Resident #137 was cognitively intact and was not experiencing shortness of breath or receiving oxygen. Nursing documentation dated 8/23/2022 revealed when Resident #137 developed shortness of breath, oxygen was applied. Nursing documentation dated 9/11/2022 revealed Resident #137 continued to use oxygen at 2 liters per minute via nasal cannula. Review of the physician's orders for Resident #137 revealed no written order for the use of oxygen in the electronic medical record. Review of Resident #137's August 2022 and September 2022 Medication Administration Records (MAR) and Treatment Administration Records (TAR) revealed no orders for the use of oxygen. Resident #137's revised care plan dated 9/5/2022 revealed no focus area for oxygen use.	F 695	F695 Resident Affected: Resident #137 order was placed for continuous oxygen at 2 liters/minute via nasal cannula for SOB and deceased oxygen stats and oxygen is use signage was placed on her door, September 14, 2022, prior to the survey exit by the Unit Manager. Residents with Potential to be Affected: On September 19, 2022 an audit of all residents with oxygen were reviewed for appropriate order transcription in the Electronic Medical Record (EMR), and oxygen in use signage on the door by the Director of Nursing and Unit Manager. Additional oxygen in use signage was placed in nursing supply room for easy accessibility. Systematic Changes: Effective October 11, 2022 the Director of Nursing, Unit Manager and Staff Development Coordinator provided education to all facility and agency licensed nurses on residents that require oxygen therapy must have an oxygen in use signage on their door and an order for	

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F 695	Continued From page 30 On 9/12/2022 at 11:10 a.m., Resident #137 was observed lying in the bed receiving humidified oxygen at 2 liters per minute via nasal cannula. There was no cautionary signage observed on the door, door frame and outside the room. On 9/12/2022 at 11:14 a.m. in an interview with Nurse #5, she stated there should be cautionary signage on the door for oxygen in use. On 9/14/2022 at 10:33 a.m. in an interview with Nurse #2, she stated on 8/23/2022 when Resident #137 became short of breath the physician was in the facility and assessed Resident #137. She stated the physician gave her a verbal order for the use of oxygen, and the physician usually entered the oxygen orders. On 9/14/2022 at 10:48 a.m. in a follow-up interview with Nurse #5, she stated there needed to be a physician order to administer oxygen to Resident #137, and oxygen orders were communicated on the MAR. Nurse #5 reviewed Resident #137's MAR and stated there was no orders for oxygen use on Resident #137's MAR. She stated on 9/12/2022 when she put an "oxygen in use" cautionary sign on the door. On 9/14/2022 at 3:17 p.m. in an interview with the Director of Nursing, she stated the nurses or physician should have entered an order for the use of oxygen into Resident #137's electronic medical record, and a cautionary signage indicating oxygen in use should be on the door.	F 695	oxygen usage must be transcribed in EMR. Education included that additional signage located in the nursing supply room for easy accessibility. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process. Monitoring: The Director of Nursing, Unit Manager or Staff Development Coordinator will complete monitoring of four (4) residents with identified need for oxygen for appropriate order and signage three (3) times weekly for 4 weeks, then weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report these finding to the interdisciplinary team during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. Completion Date: October 14, 2022	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide	F 745		10/14/22

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F 745	Continued From page 31 medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to arrange transportation to a resident's scheduled appointment with their orthopedic surgeon for 1 of 1 resident reviewed for medically related social services (Resident #32). Findings included: Resident #32 was readmitted to the facility on 6/29/22 with diagnoses that included a hip fracture. The quarterly Minimum Data Set (MDS) dated 7/1/22 revealed Resident #32 had moderate cognitive impairment. A review of Resident #32's Discharge Summary from a local hospital revealed Resident #32 had a follow-up appointment with his orthopedic surgeon on 7/13/22 at 1:00 PM. On 9/15/22 at 10:22 AM an interview was conducted with the facility transporter. He stated he remembered taking Resident #32 to a doctor's appointment but couldn't remember when. An interview was conducted with the Director of Nursing (DON), and she stated the admissions person is responsible for scanning the discharge summaries and then emailing them to the transporter if an appointment has been scheduled. The DON stated the facility does not have an admission person at this time and she	F 745	F745 Resident Affected: Residents #32 attended his orthopedic appointment 8/9/2022. Residents with Potential to be Affected: On October 12, 2022 the Director of Nursing and Unit Managers conducted a 100% audit of all newly admitted residents in the past 30 days of their discharge summaries for appointments. Those residents' identified appointments were reviewed by nursing and scheduled by the Transportation Director accordingly. Systematic Changes: Effective October 11, 2022, all licensed nurses were educated by the Staff Development Coordinator, Director of Nursing or Unit Manger on reviewing discharge summaries of newly admitted residents upon admission and post appointment summaries. The Regional Director of Clinical Services educated the nurse leaders (Director of Nursing and Unit Managers) on reviewing the discharges summaries on newly admitted residents during the morning clinical	

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F 745	Continued From page 32 does not know what happened. She stated the discharge summary was not scanned and sent to the transporter. She stated the resident's daughter called the facility about the appointment and it was realized transportation had not been scheduled for Resident #32's appointment. She stated they found the discharge summary with the scheduled appointment one hour past his appointment time. The DON stated the physician's office was called to see if Resident #32 could still be seen. Resident #32 could not be seen on 7/13/22 due to being late for his appointment. The next available appointment for Resident #32 was scheduled for 8/9/22. An interview was conducted with the Administrator on 9/16/22 at 4:43 PM and she stated she expected the transporter to be notified of scheduled appointments and residents go to those appointments.	F 745	meeting and upon return from medical appointments. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the new hire orientation. Monitoring: Using a facility created audit tool, the Director of Nursing, Unit Manager or Staff Development Coordinator will complete the audit to ensure residents are being transported to their appointments as originally scheduled. An audit will be completed with each new admission, weekly x 4 weeks then once (1) a week x 8 weeks then ongoing as needed to ensure compliance. The Administrator will report findings to the Quality Assurance Performance Improvement Committee monthly for 3 months and make changes to the plan as necessary to maintain continued compliance. Completion Date: October 14, 2022	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		10/14/22

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F 756	Continued From page 33 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and the Pharmacy Consultant interview, the facility failed to respond to a Medication Regimen Review on the length of time for an as needed (PRN) psychotropic medication for 1 of 5 (Resident #58) residents reviewed for unnessary medications. Findings included:	F 756	F 756 Resident Affected: Resident #58 prn order of lorazepam was discontinued on 8/8/2022. Residents with Potential to be Affected:	

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F 756	Continued From page 34 Resident #58 was admitted to the facility on 8/23/2019, with a re-entry from a hospital on 3/11/2021. Resident #58 had cumulative diagnosis that included depression, bipolar, and schizophrenia. A physician's order initiated on 4/14/2022 read in part "Lorazepam tablet 1 milligram (mg), give 1 tablet by mouth every six hours as needed." The order was discontinued on 8/8/2022. Review of a Consultant Pharmacist Recommendation dated 5/19/2022 for Resident #58 showed an order for lorazepam tablet 1 mg. The instructions read give 1 tablet by mouth every 6 hours as needed (PRN). The Consultant Pharmacist Recommendation read in part "a PRN order for an anxiolytic which has been in place for greater than 14 days without a stop date. In the last 14 days this has been administered x 0. It was administered x 3 in the last thirty days on 4/21, 4/28, and 4/29." The consultant pharmacist recommendation was not signed by a physician as being reviewed. A Consultant Pharmacist Medications Regimen Review (MRR) dated 6/24/2022 for Resident #58 read in part "This resident is receiving lorazepam 1mg every 6 hours PRN. Recommendations: Please evaluate continued need for the lorazepam PRN order and discontinue if no longer needed. If continued PRN dosing is necessary for this resident, please document their rationale and indicate the duration for the PRN order." Handwritten on the Consultant Pharmacist MMR read "changed to every 12 hours, will follow up on needs." The length of duration is not addressed.	F 756	Effective October 11, 2022 the Director of Nursing and Unit Managers conducted a 100% audit of all residents on PRN psychotropic medications to ensure there was an appropriate stop date. On October 11, 2022 the Director of Nursing conducted an audit of Consulting Pharmacist Recommendations for the past 2 months. Those residents identified were reviewed by the Physician. Systematic Changes: Effective October 11, 2022, all licensed nurses were educated by the Staff Development Coordinator, Director of Nursing or Unit Manger on obtaining a 14 day stop date for all PRN psychotropic medications. The Regional Director of Clinical Services educated the nurse leaders (Director of Nursing and Unit Managers) on reviewing and providing to the attending physician the pharmacy recommendations. The DON will be responsible for ensuring pharmacy recommendations are communicated to the physician and follow-up recommendations/orders are implemented by the Unit Managers. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the new hire orientation. Monitoring: The Director of Nursing or Unit Manager	

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F 756	Continued From page 35 The resident's most recent comprehensive Minimum Data Set (MDS) assessment dated 7/15/2022 indicated Resident #58 was moderately cognitively impaired. Resident #58 had no behaviors or rejection of care. The MDS further indicated Resident #58 received antipsychotic, antianxiety, and antidepressant medication on 7 of 7 days during the look back period. A Consultant Pharmacist MMR dated 7/18/2022 for Resident #58 read in part "recommend discontinuing PRN use of lorazepam for this resident or reorder for a specific number of days". The physician replied, "continue PRN use of lorazepam for 180 days as the benefit outweighs the risk." The recommendation was signed 7/21/2022. An interview with the Director of Nursing (DON) was conducted on 9/16/2022 at 11:56 A. M. During the interview, the DON indicated she will print the Consultant Pharmacy Recommendations monthly. When the reports were printed, she either handed the reports to the physician or placed them in the MD book for review. The DON indicated when the physician had completed his review, he will either hand them back to her, hand the signed reports to a unit manager, or place the reviewed reports back in the MD book. The DON confirmed the Consultant Pharmacy Recommendation dated 5/19/2022 was not signed and indicated a rationale should be documented for the medication to continue pass 14 days. During the interview, the DON indicated the physician was responsible to review all Consultant Pharmacist Recommendations and respond as required.	F 756	will conduct audits of 5 residents with PRN psychotropic medication orders for 14-day stop dates. Monitoring will be completed three (3) times weekly for 3 months and as necessary thereafter. The Consultant Pharmacist Recommendation to be audited by the Director of Nursing each month for 3 months. The Administrator or Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance Date of Compliance: October 14, 2022	

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	345081	A. BUILDING _____ B. WING _____	C 09/16/2022

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F 756	Continued From page 36	F 756		

An interview with the Physician was conducted on 9/16/2022 at 12:44 P.M. During the interview, he indicated pharmacy recommendations were given to him by the DON. When he received the recommendations, the physician reviewed the pharmacy recommendations and makes modifications to resident orders as needed. When asked about the Consultant Pharmacy Recommendation dated 5/19/2022, the Physician indicated the paper may have been included in the stack of recommendations he reviewed and was overlooked. The Physician further indicated antipsychotic medications were written for 14 days and then re-evaluated. At the time of re-evaluation, a note was written to support an extension of the medication if needed. The Physician indicated Resident #58 should have been re-evaluated if the medication was ordered PRN for over 14 days.

An interview with the Consultant Pharmacist was conducted on 9/16/2022 at 2:45 P.M. During the interview, the Consultant Pharmacist indicated when she completed her monthly review of each resident's electronic medical record (EMR), she sends the recommendations through an email to the DON and posts a report on the online pharmacy website that allows any staff with a login access to review/print the recommendations. The Pharmacist indicated when she reviewed Resident #58's EMR in June, she realized the recommendation from 5/19/2022 had not been addressed and she sent a second recommendation to the physician for review.

An interview with the DON and the Regional Nurse Consultant was conducted on 9/16/2022 at 2:30 P.M. indicated they expected the physician to review and address concerns identified on the

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F 756	Continued From page 37 Consultant Pharmacy Monthly Medication Review, to include the length of time a PRN antipsychotic was ordered before a re-evaluation was required.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/14/22

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F 758	Continued From page 38 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and the Pharmacy Consultant interview, the facility failed to obtain documentation of the rationale to extend PRN (as needed) psychotropic medication beyond 14 days and failed to have an adequate clinical indication for the use of a psychotic medication for 1 of 5 residents (Resident #47) reviewed for unnecessary medications. Findings included: Resident #47 was admitted to the facility on 7/1/2022. Resident #47 had cumulative diagnoses that included stroke and metabolic encephalopathy (a problem in the brain caused by a chemical imbalanced due to illness or organs not functioning as well as they should). The resident's most recent comprehensive Minimum Data Set (MDS) assessment dated 7/22/2022 indicated Resident #47 was able to make his own decisions for care. Resident #47	F 758	F758 Resident Affected: Resident #47 order of Olanzapine was discontinued on 9/16/22. Residents with Potential to be Affected: Effective October 11, 2022 the Director of Nursing and Unit Managers conducted a 100% audit of all residents on PRN psychotropic medications to ensure there was an appropriate stop date. Systematic Changes: Effective October 11, 2022, all licensed nurses were educated by the Staff	

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F 758	Continued From page 39 had no behaviors or rejection of care. The MDS further indicated Resident #47 had not received antipsychotic medication on 7 of 7 days during the look back period. A physician's order initiated on 9/1/2022 read in part "Olanzapine 10 milligram (mg) solution reconstituted inject 5 mg/milliliter (ml) intramuscularly every 12 hours as needed for agitation." The end date on the order was 9/30/2022. Review of the Medication Administration Record for September 2022 showed an order with a start date of 9/1/2022, that read olanzapine inject 5 mg/ml intramuscularly every 12 hours as needed for agitation until 9/30/2022. The medication was administered once 9/8/2022 and once on 9/15/2022. An interview with the Physician was conducted on 9/16/2022 at 12:44 P.M. During the interview the Physician indicated a resident may be ordered an antipsychotic to determine if the resident would benefit from the mediation. The Physician further indicated the medication should be ordered for 14 days and then the resident re-evaluated to determine if there was a benefit to the resident from receiving the medication. If the medication was extended over 14 days, then a rationale should be documented, and the resident referred to psychiatry to be monitored and diagnosed. The Physician indicated Resident #47 should not have a PRN antipsychotic ordered for thirty days. An interview with the Consultant Pharmacist was conducted on 9/16/2022 at 2:45 P.M. During the interview the Consultant Pharmacist indicated during her Monthly Medication Review (MMR),	F 758	Development Coordinator, Director of Nursing or Unit Manger on obtaining a 14 day stop date for all PRN psychotropic medications. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the new hire orientation. Monitoring: The Director of Nursing or Unit Manager will conduct audits of 5 residents with PRN psychotropic medication orders for 14-day stop dates. Monitoring will be completed three (3) times weekly for 3 months and as necessary thereafter. The Administrator or Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance. Completion Date: October 14, 2022	

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F 758	Continued From page 40 she looked for antipsychotic medications without a stop date. When asked about Resident #47's Olanzapine order, the Consultant Pharmacist indicated she had not completed Resident #47's MMR for September 2022 for approved diagnosis for each medication or the length of time ordered for PRN antipsychotic medications. During the interview the Consultant Pharmacist further stated the medication had a stop date of 9/30/22 and she would not have made a recommendation during the MMR because the medication would have stopped at the end of the month when the MMR was due. The Consultant Pharmacist indicated she was aware PRN antipsychotic medicates were limited to 14 days without exception without the physician re-evaluating the resident. An interview with the Director of Nursing (DON) and Regional Nurse Consultant was conducted on 9/16/2022 at 2:30 P.M. During the interview it was indicated any resident who received an as needed antipsychotic mediation should be evaluated after 14 days by the physician to determine if the resident benefited from the medication before the medication was extended for use over 14 days and should have a diagnosis for the medication administered.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		10/14/22

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F 812	Continued From page 41 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 record review, observations and staff interviews, the facility failed to discard expired foods stored for use in 1 of 1 walk-in refrigerator; label, date food items, monitor freezer and refrigerator temperatures, and provide a resident nourishment refrigerator solely for resident's food items brought into the facility; prevent potential cross contamination of food when a staff member (Certified Occupational Therapy Aide #1) placed a leftover food tray into the enclosed meal cart that had meal trays waiting to be served to residents for 1 of 2 meal observations; monitor temperatures on the wash cycle and the temperature during a chemical solution rinse cycle for the dish machine to ensure sanitation of dishes; and ensure 3 of 4 dietary staff (Dietary Aide (DA) #1 and Regional Director of Operations) had their hair covered while observed in the kitchen area. These practices had the potential to affect food served to 87 of the 88 residents. Finding included: 1. On 9/12/2022 at 10:15 a.m. in the initial tour of the kitchen accompanied by Dietary Aide (DA)	F 812	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60 (i)(1)(2) A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. The facility discarded all expired and unlabeled foods identified during observations that were present in the walk-in refrigerator. 2. The facility discarded all unlabeled and	

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F 812	Continued From page 42 #1, the following items were observed in the walk-in refrigerator: · Container of macaroni salad labeled prepared on 8/9/2022 and used by 9/8/2022. DA #1 removed the macaroni salad from the walk-in refrigerator and discarded. · Three small-sealed packets of unlabeled turkey with no expiration dates observed on the packets. DA #1 stated the small packets of turkey came out of the large zip lock bag labeled use by 9/12/2022 and contained an opened small packet of turkey. · Opened ham pack observed in a large zip lock bag with no label indicating date ham packet was open or date of expiration. DA #1 removed the ham from the walk-in refrigerator and discarded. · Four half cut turkey sandwiches wrapped in clear plastic wrap with no date. DA #1 discarded the turkey sandwiches DA #1 stated food items were to be labeled with a date when prepared, and food items could be used for one week if no expiration. He stated he had only been working at the facility for one month, and the cook controlled the contents in the refrigerator and deferred further questioning to the dietary cook. On 9/12/2022 at 10:34 a.m. Dietary Cook #1 stated prepared food items in the refrigerator should be labeled with the date the food item was opened or prepared and with an expiration date. She stated the ham should had been dated with an opening and expiration date and the macaroni salad removed after the expiration date. She stated Dietary Aides and Dietary cooks checked the walk-in refrigerator daily for expired items. She stated checked food items in the walk- in refrigerator for expiration before using and she	F 812	undated items that were present in the resident nourishment room refrigerator. The facility also discarded all items that were not resident nourishment items that were present in the resident nourishment refrigerator. 3. The facility discarded all unlabeled and undated items that were present in the staff lounge refrigerator. 4. The facility placed a thermometer in the resident nourishment refrigerator to record the temperature on 9/19/22. 5. The facility placed a thermometer in the staff lounge refrigerator to record the temperature on 9/19/22. 6. The facility discarded the leftover food tray that was placed on the enclosed meal cart. 7. The Maintenance Director repaired the dish washer thermometer on 9/19/2022. 8. The facility dietary aide and Regional Director of Operations for dietary placed hair nets on their heads to ensure proper hair coverage while in the kitchen. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. An audit of the staff lounge refrigerator was completed by the Maintenance Director to ensure all food is labeled and dated and any food that is outdated and unlabeled food was discarded and that temperatures were appropriate for the refrigerator. 2. An audit of the walk-in refrigerator was completed by the Dietary Manager on 9/19/22 to ensure all food is labeled and dated and any food that is outdated and	

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F 812	Continued From page 43 stated the serving line tray had been broke for the last month and she was busy that morning boiling water for the serving line and had not checked the refrigerator for expired food items. The facility's Dietary Manager was not available for interview during the survey. On 9/14/2022 at 10:53 am. in an interview with the contracted dietary company's Dietary Manager, he stated food items stored in the walk-in refrigerator should be labeled when open or prepared and with an expiration date. He stated the turkey in the plastic seal package should had been labeled with an expiration date based on the manufacture's expiration on the packaging care. He stated ham could be used one week after opening the package if labeled when opened and anything with eyes or mayonnaise expired within five day and should be discarded. On 9/14/2022 at 11:50 a.m. accompanied by Dietary Cook #2, observed a tray of half cut turkey sandwiches wrapped in plastic not labeled with a date. Dietary Cook #2 stated the evening shift dietary staff on 9/13/2022 made too many sandwiches and the turkey sandwiches would be use for bedtime snack on 9/14/2022. He stated food items in the walk-in refrigerator were to be dated with a preparation or open date and an expiration date. The following items were observed in the walk-in refrigerator: · Small-sealed package of turkey not labeled with no expiration date · Opened small package of turkey dated open on 9/6/2022 with an expiration date 9/12/2022 in a zip lock bag · Lemon pudding in a clear plastic	F 812	unlabeled food was discarded and that temperatures were appropriate for the refrigerator. 3. An audit of the resident nourishment refrigerator was completed by the Dietary Manager on 9/19/22 to ensure all food is labeled and dated and any food that is outdated and unlabeled food was discarded and that temperatures were appropriate for the refrigerator. 4. A refrigerator was ordered for the resident nourishment room by the NHA on 9/19/2022 it was delivered on 9/21/2022. 5. An audit of the dish machine was completed by the Maintenance Director on 9/19/22 to ensure the temperature during a chemical solution rinse cycle for the dish machine was above 120 degrees Fahrenheit. 6. The NHA completed an audit on 9/19/22 of dietary staff hair coverings to ensure that all dietary staff are wearing the proper hair coverings while working in the kitchen 7. The Dietary Manager re-educated current dietary staff on 9/20/22 that it is their responsibility to label and date food prior to placing in the walk-in refrigerator or walk in freezer. All newly hired dietary staff will be educated on labeling and dating food prior to placing in the walk-in refrigerator or walk-in freezer. 8. The Staff Development Coordinator (SDC) educated all staff on 9/20/22 on cross contamination of putting dirty trays on clean meal carts, and to not put resident food in the staff refrigerator. All newly hired staff will be educated on cross contamination of putting dirty trays on	

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F 812	Continued From page 44 container labeled use by 8/16/2022 Dietary Cook #2 removed the turkey and lemon pudding from the walk-in refrigerator and discard the items in the trash. He stated the lemon pudding was probably dated wrong and he was just reporting to work to prepare the evening meal. On 9/14/2022 at 12:15 p.m. in a follow-up interview with the contracted dietary company's Dietary Manager, he stated the dietary manager and dietary cooks monitor and rotate the food items in the refrigerator while attempting to use food items before the expiration date. He stated food items with expiration dated should be removed from the walk- in refrigerator. On 9/14/2022 at 2:22 p.m. in an interview with the Administrator, she stated food items should be labeled and dated with an opened or prepared date and a expiration date when placed the walk-in refrigerator. She stated expired food should be discarded as indicated on the labeled. 2. On 9/14/2022 at 6:35 a.m. in an interview with Nurse #7, she stated resident food items were stored in the staff lounge refrigerator. Accompanied by Nurse #7 to the staff lounge, a large upright refrigerator was observed. There was no signage indicating the upright refrigerator was used for storage of resident foods and there was no thermometer observed in the freezer and refrigerator compartments. The following items were observed in the freezer compartment: · Opened ranch dressing bottle dated 3/28/2021 · Frozen dinner (labeled country fried steak, boiled potatoes, green beans) dated	F 812	clean meal carts, and to not put resident food in the staff refrigerator. 9. The Dietary Manager educated dietary staff on 9/20/22 on wearing hair nets in the kitchen. All newly hired dietary staff will be educated on wearing hair nets in the kitchen. 10. The Administrator in-serviced the Maintenance Staff and Dietary Staff on the appropriate temperatures for the resident nourishment room refrigerator, the staff lounge refrigerator and the dish machine in the kitchen. All newly hired maintenance and dietary staff will be educated on the appropriate temperatures for the resident nourishment room refrigerator, the staff lounge refrigerator and the dish machine in the kitchen. C. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The facility Maintenance Director will audit the staff lounge refrigerator 3 times a week for four weeks, then 2 times a week 4 weeks, then monthly for three (3) months using the Staff Lounge Refrigerator Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. 2. The facility Maintenance Director will audit the dish machine temperatures 3 times a week for four weeks, then 2 times a week 4 weeks, then monthly for three (3) months using the Dish Machine Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting	

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F 812	Continued From page 45	F 812		

prepared on 8/31/2022. There was no expiration date or resident's name on the frozen dinner.
· Two frozen food trays with contents unknown with no label indicating resident's name or date of expiration
The following items were observed in the refrigerator compartment:
· Opened bowl of unidentifiable food with no label indicating resident's name or date prepared
· Four small grocery bags with various food items and drinks with no resident ' s name or date items were placed in the refrigerator.
· One grocery bag tied closed labeled with a resident's name and dated 9/13/2022
Nurse #7 stated she placed the grocery bag with the resident's name and date into the refrigerator last night for the resident. Nurse #7 stated she did not know anything about checking freezer and refrigerator temperatures and directed that questioning for the Director of Nursing.

On 9/14/2022 at 6:42 am, Nurse #8 stated resident foods were stored in the activity dining room refrigerator.

On 9/14/2022 at 6:50 a.m. in an interview with the Director of Nursing (DON), she stated before renovations started a month ago, resident's food items were stored in a locked resident's refrigerator in the activity dining room and she did not know where resident's food items brought in by family or visitors was stored at this time. The DON was informed Nurse #7 stated the staff lounge refrigerator was used as the resident refrigerator and was informed of the contents observed in the staff lounge refrigerator. The DON stated the resident refrigerator should be placed in a universal located solely for storage of

monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.
3. The Staff Development Coordinator (SDC) will audit cross contamination of putting dirty trays on clean meal carts 3 times a week for four weeks, then 2 times a week 4 weeks, then weekly for four weeks using the Meal Pass Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.
4.The Staff Development Coordinator (SDC) will audit the Resident Nourishment Refrigerator, 3 times a week for four weeks, then 2 times a week 4 weeks, then monthly for three (3) months using the Resident Refrigerator and Walk-in Refrigerator Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing
5. The facility Dietary Manager will audit the Walk-in Refrigerator 3 times a week for four weeks, then 2 times a week 4 weeks, then monthly for three (3) months using the Walk-in Refrigerator Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.

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F 812	Continued From page 46 resident foods and locked with staff access for the residents. She stated resident items placed in the refrigerator should be labeled with resident's name and date food items were placed in the refrigerator, and the items were not considered expired for thirty days. She stated housekeeping or herself would clean out the staff lounge upright refrigerator. She stated nourishment refrigerators for residents required a freezer and refrigerator thermometer internally and temperatures should be checked daily on the night shift to assure the temperature of the freezer and refrigerator were within a certain freezing and cooling range. The DON was informed the upright refrigerator in the staff lounge was did not have internal thermometers to check freezer and refrigerator temperatures. The facility's Dietary Manager was not available for interview during the survey. On 9/14/2022 at 10:53 p.m. in an interview with Contracted Company's Dietary Manager, he stated he did not know where the resident nourishment refrigerator was located and who was responsible for maintenance of the contents in the resident nourishment refrigerator. On 9/14/2022 at 2:22 p.m. in an interview with the Administrator, she stated she didn't know the nursing staff were using the staff lounge refrigerator to store resident food items. She stated the resident nourishment refrigerator required internal thermometers for the temperatures to be checked in the freezer and refrigerator daily, and the staff lounge refrigerator was not equipped with thermometers. She also stated the staff lounge refrigerator should be labeled indicating "use for resident foods only".	F 812	6. The facility NHA will audit dietary usage of hair nets 3 times a week for four weeks, then 2 times a week 4 weeks, then monthly for three (3) months using the Hair Net Audit Tool. The results will be presented by the NHA in the monthly QAPI Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. The NHA and/or designee will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. The facility alleges compliance on 10/14/2022.	

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She stated expired food items and the unlabeled foods items in the staff lounge refrigerator needed to be removed.

On 9/15/2022 at 2:45 p.m. in an interview with Nurse #4, she stated resident foods were stored in the staff refrigerator. Accompanied with Nurse #4 to the staff lounge, there was no signage observed indicating "for resident use only", no internal thermometers observed in the freezer or refrigerator and the unlabeled and expired contents remained in the freezer and refrigerator form 9/14/2022. Nurse #4 stated the facility did not have a nourishment refrigerator or nourishment room for the residents.

In a follow up interview with the Administrator on 9/15/2022 at 3:27 p.m., she stated the facility did not have a nourishment room at this time for the residents. She stated the activity dining room was under renovations where the resident nourishment refrigerator was located. She stated due to the resident nourishment refrigerator not working, it was removed from the facility when renovations started a month ago. She stated she had not ordered another refrigerator because undecided where to place the resident nourishment refrigerator in the facility. In a follow-up interview with the Administrator on 9/15/2022 at 3:38 p.m., she stated the expired food items and unlabeled food items in the staff lounge refrigerator had been discarded.

3. On 9/14/2022 at 12:36 p.m., Dietary Aide (DA) #1 was observed exiting the kitchen with a closed meal cart with resident meal trays inside and delivering the meal cart in the hallway outside Resident #200's room.

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On 9/14/2022 at 12:38 p.m., Certified Occupational Therapist Aide #1 (COTA) was observed exiting Resident #200 ' s room carrying a leftover meal tray and returning the leftover meal tray with the styrofoam plate closed to the bottom of the closed meal cart DA #1 had delivered outside Resident #200 ' s room.

On 9/14/2022 at 12:45 p.m. prior to Nurse #6 moving the closed meal cart located outside Resident #200's room to another hall to deliver residents their meal trays, Nurse #6 was informed a leftover meal tray was place on the closed meal cart by COTA #1. Nurse #6 was observed removing the leftover meal tray off the meal cart outside Resident #200's room and placing on another empty closed meal cart in the hallway. Nurse #6 was observed moving the closed meal cart with meal trays for the residents to another hallway, and three dietary aides were observed delivering the meal trays to the residents.

On 9/14/2022 at 2:13 p.m. in an interview with COTA #1, she stated Resident #200's meal tray had been delivered to the resident when she arrived to provide diet therapy, and she knew not to place dirty meal trays on a meal cart with meal trays waiting to be served to residents. She stated when she placed Resident #200 ' s dirty meal tray on the lunch meal cart located in the hallway outside Resident #200's room, she did not know which meal cart Resident #200's meal tray had come from and did not realize the meal trays on the lunch meal cart located outside Resident 200's room were waiting to be served.

On 9/14/2022 at 2:22 p.m. in an interview with the Administrator, she stated to prevention cross contamination, COTA #1 should had carried the

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dirty meal tray to the kitchen area when exiting Resident #200 ' s room instead of returning the dirty meal tray to the lunch meal cart with meal trays waiting to be served to residents.

4. A label on the low temperature dish machine stated minimum water temperatures for the wash and rinse temperatures was 120 degrees F.

On 09/15/22 at 9:20 a.m., DA #1 was observed racking and washing breakfast dishes using the low temperature dish machine. The thermometer of the low dish machine was set at 90 degrees Fahrenheit and did not move with wash and rinse cycles of the dish machine. There was no evidence of a temperature or chemical solution log in the kitchen wash area.

The facility's Dietary Manager was unavailable for interview during the survey.

On 9/15/2022 at 12:25 p.m. in an interview with Dietary Aide (DA) #2, he stated he did not know what the wash and rinse water temperatures were to reach for sanitation for the dish machine. He stated the dietary staff ran the dish machine through a few cycles of wash and rinse for the water temperature to increase before washing the dishes.

On 9/15/2022 at 12:43 p.m. in an interview with DA #1, he had worked at the facility for one month and had not checked the wash and rinse water temperatures of the dish machine.

On 9/15/2022 at 12:52 p.m. in an interview with the Regional Director of Operations for dietary, he stated he was at the facility this day due to the absence of the facility's Dietary Manager. He

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stated thermometer on the dish machine needed to be repaired and had submitted a work order.

On 9/15/2022 at 1:03 p.m. in an interview with the Administrator, she stated she was not aware the thermometer on the dish machine was not working during the wash and rinse cycles prior to the Regional Director of Operations informing her on this day.

On 9/15/2022 at 1:38 p.m. in an interview with the Maintenance Director, he stated he was not notified the thermometer on the dish machine was not working and the company of the dish machine needed to be called to repair the thermometer on the dish machine.

On 9/16/2022 at 2:28 p.m. in a follow up interview with the Administrator, she stated the facility was required to have a thermometer on the dish machine to register the sanitation process in cleaning of the dishes, and the thermometer on the dish machine would need to be replaced.

5. On 9/15/2022 at 9:20 a.m. Dietary Aide (DA) #1 was observed inside the dish wash area not wearing a hair covering and the Regional Director of Operations (RDO) for dietary was observed walking through the kitchen and exiting the kitchen without wearing a hair covering.

On 9/15/2022 at 9:21 a.m. in an interview with the RDO, he stated dietary staff needed to wear hair coverings when in the kitchen area, and he had forgot to apply a hair covering that morning.

On 9/15/2022 at 12:43 p.m. in an interview with

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F 812	Continued From page 51 Dietary Aide #1, he stated hair coverings were to be worn when in the kitchen. He stated he forgot to put a hair net and did not realize he was not wearing a hair covering when he was washing the morning dishes. The facility's Dietary Manager was not available for interview during the survey. On 9/15/2022 at 1:03 p.m. in an interview with the Administrator, she stated hair coverings were to be worn by dietary staff and anyone entering the kitchen areas.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §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 interviews, and physician interviews the facility's Quality Assessment and Assurance Committee failed to maintain and implement procedures and monitor interventions the committee put into place following the recertification and complaint survey on 5/11/21 and the recent recertification and complaint survey on 9/16/22. This was for 1 deficiency that was cited in the area of care plan timing and revision (F657) and recited on the current recertification and complaint survey of 9/16/22. The duplicate citations during 2 federal surveys of record shows a pattern of the facilities inability to	F 867	F867 Quality Assessment and Assurance 1. Process that leads to the deficiency: The facility failed to accurately care plan for oxygen use and wound care, identification of trends, or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. 2. On 9/19/2022, The Regional of Clinical Services conducted re-educated for the Administrator on the facility's Quality Assessment and Assurance Committee (QAA) Program including the	10/14/22

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F 867	Continued From page 52 sustain an effective QAA program. Findings Included: This tag was cross-referenced to: 1. (F657) Based on record review, resident interview and staff interviews, the facility failed to conduct a care plan meeting for 1 of 2 residents reviewed for care planning meeting and failed to revise the care plan observed using oxygen by nasal cannual for 1 of 1 resident reviewed for the use of oxygen. Based on observation, staff interview and record review, the facility failed to initiate a care plan for a pressure ulcer for one of one resident reviewed for pressure ulcers. On 09/16/22 at 4:35 PM the Director of Nursing and Administrator were interviewed, and both stated there has been lots of turnover with staff at the facility. They stated audits and new procedures were just not followed.	F 867	active diagnoses on residents. All members of the Quality Assessment and Assurance Committee (QAA)submit data related to each department and participate in the identification of areas in need of improvement. 3. The monitoring process and systemic changes The Administrator and the Director of Nursing will present the results of all audits of MDS assessments, care plans to the Quality Assessment and Assurance (QAA) committee weekly for four (4) weeks and then monthly thereafter. The next Quality Assessment and Assurance Committee meetings will be conducted weekly for four (4) weeks then monthly with oversight by Regional Nurse for three (3) months. 4. Measures to ensure that corrections are achieved & sustained include having a traveling MDS come in 3x a week and assist with care plans and assessments along with the full MDS. The DON will present the audits to the QAA Committee weekly for four (4) weeks then monthly x 3 months. The results of this review will be reported to the Quality Assurance Performance Improvement Committee Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. 5. The monitoring procedure to ensure the plan of correction is effective and	

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F 867	Continued From page 53	F 867	specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate 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. The facility alleges compliance on 10/14/2022.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain the dish machine in operating condition as evidenced by the temperature gauge not working during the wash and rinse cycles and failed to repair a sink allowing for draining in the kitchen area for 87 of 88 residents. Findings included: 1. A review of dietary work orders since December 2021 revealed no work orders for the dish machine thermometer. A label on the dish machine stated minimum	F 908	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F908 Essential Equipment, Safe	10/14/22

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F 908	Continued From page 54 water temperatures for the wash and rinse temperatures was 120 degrees F. On 9/15/2022 at 9:20 a.m., while observing the dietary staff washing the breakfast dishes, the dish machine thermometer was observed set at 90 degrees Fahrenheit (F) and not moving during the dish machine's wash and rinse cycles. Steam was observed escaping from the basin of water outside the dish machine. The Regional Director of Operations for dietary was observed using a manual thermometer to check the water temperature of the water released from the dish machine. The released wash water temperature was observed to measure 113 degrees F and the released rinse cycle temperature was observed to measure 133-144 degrees F. On 9/15/2022 at 9:35 a.m., the Regional Director of Operation for dietary requested a recheck on the dish machine temperatures. The Regional Director of Operations stated the dietary aides informed him after running cycles of wash and rinse through the dish machine the temperature would increase. The dish wash thermometer was observed stationary at 90 degrees F while the released water temperature during the wash cycle and rinse cycle were checked manually by the Regional Director of Operations for dietary. Released wash water temperature was observed measuring 135 degrees F manually and released rinse water was observed measuring 145 degrees F. The facility's Dietary Manager was unavailable for interview during the survey. On 9/15/2022 at 12:25 p.m. in an interview with Dietary Aide (DA) #2, he stated the thermometer	F 908	Operating Condition CFR(s): 483.90 (d)(2) A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. The temperature gauge was fixed on 09/20/2022 by the Maintenance Director. The dish washer now holds the proper temperature. The pipes under the sink were replaced on 09/20/2022 and is draining properly. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. On 09/20/2022, The Maintenance Director completed an audit of the dish washer temperature gauge and all pipes connected to the sinks in the kitchen. No concerns were noted from this audit. 2. All dietary staff will be educated on ensuring the temperature gauge is functioning properly and that all pipes in the sinks are drain appropriated by the Maintenance Director. All newly hired dietary staff will receive education on ensuring the temperature gauge is functioning properly and that all pipes in the sinks are drain. 3. The Dietary Manager educated staff on 09/20/22 on placing a work order for broken equipment. All newly hired dietary staff will receive education on placing a work order for any broken equipment in the kitchen. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The facility Maintenance Director and/or	

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F 908	Continued From page 55 to the dish machine had been broken for months. He stated he had told the Dietary Manager (DM) and was unsure if the DM had notified anyone the thermometer was not working. He stated he did not know what the wash and rinse water temperatures were to reach for sanitation for the dish machine. He stated the dietary staff ran the dish machine through a few cycles of wash and rinse for the water temperature to increase before washing the dietary dishes. On 9/15/2022 at 12:31 p.m. in an interview with the Dietary Cook #1, she stated dietary staff ran wash and rinse cycles through the dish machine until the water was hot before washing the dishes. She stated she was the cook now and did not know the thermometer was not working on the dish machine. On 9/15/2022 at 12:43 p.m. in an interview with DA #1, he stated he had worked at the facility for one month and had not checked the wash and rinse water temperatures of the dish machine. He stated he did not know the thermometer to the dish machine was not working. On 9/15/2022 at 12:52 p.m. in an interview with the Regional Director of Operations for dietary, he stated he was at the facility this day due to the absence of the facility's Dietary Manager. He stated thermometer on the dish machine needed to be repaired and had submitted a work order. On 9/15/2022 at 1:03 p.m. in an interview with the Administrator, she stated she was not aware the thermometer on the dish machine was not working during the wash and rinse cycles prior to the Regional Director of Operations informing her on this day.	F 908	designee will audit the dishwasher temperature gauge and correct drainage for sinks in the kitchen using the Kitchen Audit Tool five (3) times a week for 4 weeks, then two times a week for 4 weeks, then weekly for 4 weeks, and ongoing as needed. The Administrator or DON will report findings to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. The Administrator and/or designee will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. The facility alleges compliance on 10/14/2022.	

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On 9/16/2022 at 2:28 p.m. in a follow up interview with the Administrator, she stated the facility was required to have a thermometer on the dish machine to register the sanitation process in cleaning of the dishes, and the thermometer on the dish machine would need to be replaced.

2. A review of kitchen work orders since December 2021 revealed no work order for the large sink without drainage pipes located in the dish wash area.

On 9/25/2022 at 12:25 p.m. a large pan of water was observed under the large sink in the dish wash area. There were no pipes observed exiting from under the sink to the floor for drainage of water from the sink.

On 9/15/2022 at 12:25 p.m. in an interview with Dietary Aide (DA) #2, he stated the sink the dish wash area was used to rinse dishes before stacking and washing in the dish wash machine. He stated the male staff emptied the pan of water every shift and as needed. He stated since he had been working at the facility for the last year, the sink had been without drainage pipes from under the sink to the floor.

On 9/15/2022 at 12:43 p.m. in an interview with DA #1, he stated he had to use containers to empty drinks and water for silverware to soak since the large sink in the wash area in the kitchen did not have drainage pipes. He stated he was unsure how long the facility had been using a pan to collect the water from the large sink in the wash area and he had worked at the facility for one month with no drainage pipes from the sink.

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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 908	Continued From page 57 The facility's Dietary Manager was unavailable for interview during the survey. On 9/15/2022 at 1:03 p.m. in an interview with the Administrator, she stated she was unaware the large sink in the wash area did not have drainage pipes and staff were using a pan to collect drainage water out of the sink. On 9/15/2022 at 1:38 p.m. in an interview with the Maintenance Director, he stated he was told in June 2022 three-inch drainage pipes were not available for the large sink in the wash area in the kitchen, and the sink needed to be replaced. He stated he had been out of work the month of August and needed to find a company to replace the sink. On 9/16/2022 at 2:28 p.m. in a follow-up interview with the Administrator, she stated the large sink in the dish wash area had been tagged out for staff not to use until another sink was instal	F 908		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain a sanitary environment by having cigarette butts littered throughout the courtyard and smoking area for 1 of 1 outdoor courtyard designated for smoking. Findings Included:	F 921	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or	10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 09/16/2022

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F 921	Continued From page 58 An observation of the facility's smoking area on 09/07/22 09:30 AM revealed 2 entrances and 2 exits. Continued observation also revealed 78 cigarette butts littered throughout the facility's courtyard. An interview with the facility's Housekeeping Director on 09/07/22 at 9:31 AM who was in the courtyard of the facility at the time of interview, revealed the housekeeping department was responsible for cleaning the courtyard area including sweeping and removing the cigarette butts and acknowledged the cigarettes butts should not be on the ground and did not have a record of when the courtyard was last cleaned. The Housekeeping Director also stated the cigarette butts should be disposed in a collection container, then emptied in a secure trash can, and the courtyard should be swept daily. There were three residents observed smoking in the courtyard at the time of this interview. An interview with the Administrator on 09/08/22 at 11:17 AM revealed she was unaware of the amount of cigarette butts scattered throughout the courtyard and stated housekeeping staff were responsible for cleaning the courtyard. The Administrator added she was not sure when the last cleaning of the courtyard took place.	F 921	conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. F921 Safe/Functional/Sanitary/Comfortable Environment CFR(s): 483.90(i) A. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: 1. On 09/08/2022 the Maintenance Director cleaned the facility's courtyard and smoking area to remove the cigarette butts. B. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: 1. On 09/08/2022, The Maintenance Director completed an audit of the entire facility grounds to clean any cigarette butts that may be present. 2. On 09/09/2022, the Maintenance Director completed an audit of the resident smoking area to ensure that the area was free of cigarette butts. 3. On _____ all staff were educated on maintaining a safe, functional, sanitary, and comfortable environment to include placing cigarette butts in the appropriate waste container. All newly hired staff will be educated on maintaining a safe, functional, sanitary, and comfortable environment to include placing cigarette butts in the appropriate	

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F 921	Continued From page 59	F 921	waste container. 4. On 10/11/22, all residents that smoke were educated on where to safely extinguish their cigarettes. C. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: 1. The facility Maintenance Director and/or designee will audit the facility grounds using the Facility Grounds Environmental Audit Tool five (3) times a week for 4 weeks, then three (2) a week for 4 weeks, then weekly for 4 weeks, and ongoing as needed. The Administrator or DON will report findings to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance. D. Monitoring of corrective action to ensure the deficient practice will not reoccur: 1. The Administrator and/or designee will be responsible for overseeing all audit of findings and subsequent disciplinary action, if applicable, will be reported to the facility QAPI Committee monthly for three months to review the need for continued intervention or amendment of plan. The facility alleges compliance on 10/14/2022.	