STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 08/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT GREENSBORO, LLC	109 S HOLDEN RD GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/15/22 through 08/19/22. The facility was found to compliance with the requirement CPR 483.73, Emergency Preparedness. Event ID #1MVN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/15/22 through 08/19/22. Event ID #1MVN11. The following intakes were investigated: NC00192056, NC00186751, NC00186933, NC00188071, NC00188710, NC00188828 and NC00191303. 2 of the 32 complaint allegation were substantiated resulting in deficencies. Immediate Jeopardy was identified at: CFR 483. 25 at tag F684 at a scope and severity K CFR 483. 45 at tag F756 at a scope and severity K Immediate Jeopardy began on 04/21/2022 and was removed on 08/18/2022 for F684. Immediate Jeopardy began on 04/27/2022 and was removed on 08/19/2022 for F756. An extended survey was conducted.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		9/14/22

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

Electronically Signed | 09/08/2022

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F 600	Continued From page 1 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, family and staff interviews, the facility, failed to protect a resident's right to be free from mistreatment by a staff member (Nursing Assistant #1) due to being "rough" while providing care, making disrespectful comments, and staff members (Nursing Assistants #2 and #4) were observed to continue to provide activities of daily living on Resident #3 while being resistive to care for 1 of 2 residents reviewed for mistreatment (Resident#3). The findings included: Resident #3 was admitted to the facility on 04/28/22 with diagnoses of Dementia with behavioral disturbances and Alzheimer ' s disease. Resident #3 ' s admission Minimum Date Set (MDS) dated 05/04/22 indicated Resident #3 had cognitive impairment and required extensive assistance with 2-person physical assist with bed mobility, dependent with 2-person physical assist	F 600	1. When Administration was informed of the allegation on 8/15/2022 the nursing assistant #1 was removed from the building and suspended pending investigation, investigation was initiated, and the Initial Report for alleged abuse was submitted for resident #3. Nursing assistant #1 was terminated from employment 8/19/2022. Nursing assistant #2, #4 were re-educated on procedures for dealing with residents who are resistive to activities of daily living care on 8/16/2022. 2. Starting on 8/16/2022, alert and oriented residents (BIMS >8) were interviewed to identify others that may have concerns regarding treatment from CNAs. Skin assessments were done for cognitively impaired residents (BIMS <8). Interviews and skin checks were completed 9/7/2022. 3. Effective 8/15/2022 the Staff Development Coordinator educated the	

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F 600	Continued From page 2	F 600		

with transfer, toilet use, extensive assistance of one-person physical assist with eating.

A review of care plan dated 5/3/22 and last revised on 7/15/22 revealed Resident #3 was resistive to care by exhibiting aggressive behaviors by biting, kicking, punching at staff, and screaming and yelling profanities. The goal was Resident would cooperate with care through next review. Interventions included staff were to give clear explanation of all care activities prior to an as they occur during each contact and make sure resident is safe, leave and reapproach resident once she is calm.

During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3 ' s Nurse (Nurse #2) around 5:00pm on Sunday Aug 14, 2022, NA #1 was in Resident #3 ' s room providing care and "yanked her leg very aggressive and told Resident you better stop." She indicated Resident had Dementia and could be resistive at times when staff provide care.

A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3 ' s family member reported that the assigned NA rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call.

staff residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Education is to include how to recognize when a resident has potentially been abused. Educated included when a resident is resistive to care, staff members are to allow the resident to calm down and reapproach to provide care to the resident. If resident continues to remain resistive the certified nursing aide will notify the nurse and the representative party will be called. Education will continue in orientation with new hire. In-person and/or via phone.
4. Administrative team will observe 2 staff members per unit providing activities of daily living to a resident to ensure staff is not providing care to a resident that is resistive care and listen to ensure staff are not making disrespectful comments towards residents' random days to include weekends on random shifts 3 x week x 4 weeks and weekly x 4 weeks. Administrative team will interview 2 residents per unit with BIMS >8 to ensure resident is not being abused weekly x 8 weeks. Nursing will perform a head-to-toe skin assessment on 2 residents per unit with BIMS <8 to ensure no signs of abuse weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director

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F 600	Continued From page 3 An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member were arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3. An interview was conducted on 8/15/22 at 5:49 pm with NA #1 and he indicated he was providing care for Resident #3 on 8/14/22 while the family member was present. He indicated during care he asked Resident #3 to stop being so aggressive so he could provide care for her. He indicated the family stated he looked a little frustrated, and the family member followed him down the hall. He stated he then called the manager on call because the family member was yelling and cussing at him, and he was told by the Manager on call to go home and return to work the next day. During this interview NA #1 indicated he was present in the dining room at the facility because he was told to come back to work at 2:00 pm on 8/15/22 and was working on the other side of the hallway and around 4:00 pm he was asked by the Director of Nursing to write a statement of what happened on Sunday. He stated he was not being aggressive with the resident and that the resident was aggressive at	F 600	of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	

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F 600	Continued From page 4	F 600		

times and yells when care provided. He indicated it takes 2 people to help with Resident and he and another NA was providing care for Resident, and the other NA left the room briefly to get some soap.

An interview was conducted with NA #5 on 8/15/22 at 6:08 pm and it was indicated she was asked by NA #1 to help provide care for Resident #3. NA #5 indicated she was not present during the entire time with NA #1 and the family. NA #5 stated NA #1 had already been in the room prior to asking her to help.

During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful.
On 8/19/22 at 10:46 am an observation was made of NA #2 and NA #4 inform Resident prior to beginning care they were going to provide activities of daily living care. NA #2 attempted to wash Resident's face and Resident began to hit at staff cursing and moving about in bed. NA #4 was holding Resident ' s hands and attempting to take clothing off and Resident continued to hit and resist staff. Surveyor intervened and informed staff to go get Nurse. Surveyor went to desk with NA #2 and Nurse stated she had given Resident some Tylenol and they stated they would make the DON aware.

During an interview on 8/19/22 at 10:54 am with NA#2 it was indicated Resident #3 is like that all

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F 600	Continued From page 5 the time, fighting and resisting to let us care for her. NA #2 indicated they sometime come back later, but we just try and get it done. On 8/19/22 at 11:41 am an interview with DON was made and she indicated she believed staff would initially stop providing care when Resident #3 became resistant to care and would re approach. DON indicated it was her expectation staff would stop and reapproach resident that were being resistant during care. She indicated she would continue to educate staff and provide dementia training for caring with residents with behaviors. During an interview with the Administrator on 8/19/2022 at 1:18 pm it was indicated it sounded like staff sometimes stop care when Resident #3 was resistant to care, and he expected staff to stop when residents were resistant to care and reapproach later.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		9/14/22

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F 607	Continued From page 6 Based on record review, family and staff interview the facility failed to report the allegation of mistreatment within the specified timeframe of 2 hours. This was evident for 1 of 3 alleged abuse investigations completed by the facility (Resident #3). The findings included: The facility abuse policy 'Allegations of Abuse, Neglect, and Exploitation with the revised date of 11/01/2020 included in part: "1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e. g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury., or b. Not later 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ...," During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3's Nurse (Nurse #2) around 5:00pm on Sunday Aug 14, 2022, NA #1 was in Resident #3's room providing care and "yanked her leg very aggressive and told Resident you better stop." She indicated Resident had Dementia and could be resistive at times when staff provide care. A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3's family member reported that the assigned NA	F 607	1. When Administration was informed of the allegation on 8/15/2022 the investigation was initiated and the Initial Report for alleged abuse was submitted immediately upon notification. 2. On 8/17/2022 the Administrator audited reported allegations of abuse and/or neglect from last 60 days to verify 24 hour and 5-day reports were completed and submitted timely as required by regulation and Elder Justice Act. 3. On 8/16/2022 Regional Director of Clinical Services educated the leadership team, including the Administrator and Director of Nursing on the abuse policy which states, “Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. immediately, but not later than 2 hours after the allegation is made if the event that cause the allegation involved abuse or result in serious bodily injury., or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury…”. Effective 8/15/2022, Staff Development Coordinator educated all current staff members on reporting all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property, are reported immediately to the Administrator and/or Director of Nursing. Education will continue in orientation with new hire.	

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F 607	Continued From page 7 rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call. An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member was arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3. During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful. A review of 24-hour initial report dated 8/15/22 was sent to NC Department of Health and Human Services, Division of Health Service Regulation	F 607	In-person and/or via phone. 4. Regional Director of Operations will monitor 24 hour and 5-day reports to ensure reports are sent in according to the regulations weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 607	Continued From page 8 via fax on 8/15/22 at 6:04 pm. During an interview with the Director of Nursing on 08/19/2022 at 11:41 am, she indicated her expectation was for staff to notify the abuse compliance officer who is the Administrator and/or herself of any allegations of abuse, and the investigation would start within 2 hrs. During an interview with the Administrator on 8/19/2022 at 1:18 pm and it was indicated it appeared to a misunderstanding of the allegation. However, his expectation was any allegation of abuse had to be sent within 2 hours to the state, suspend the alleged perpetrator pending investigation.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		9/14/22

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F 610	Continued From page 9 by: Based on record reviews, staff and family interviews, the facility failed to provide protection to residents after an allegation of mistreatment for 1 of 3 residents reviewed for abuse (Resident #3) by allowing the alleged perpetrator to come back to work the next day. The findings included: Resident #3 was admitted to the facility on 04/28/22. Resident #3's admission Minimum Date Set (MDS) dated 05/04/22 indicated Resident #3 had cognitive impairment and required extensive assistance with 2-person physical assist with bed mobility, dependent with 2-person physical assist with transfer, toilet use, extensive assistance of one-person physical assist with eating. During an interview on 8/15/22 at 4:36 pm with a family member it was indicated that she had reported to staff member an allegation of a staff member handling her family member rough during patient care. She indicated she reported to Resident #3's Nurse (Nurse #2) around 5:00pm on Sunday Aug 14, 2022. NA #1 was in Resident #3's room providing care and "yanked her leg very aggressive and told Resident you better stop." She indicated Resident had Dementia and could be resistive at times when staff provide care. A review of Nurses Progress Note dated 08/14/22 at 5:03 pm read in part Resident #3's family member reported that the assigned NA rough-handled her mother and stated he was frustrated from the previous task he performed.	F 610	1. When Administration was informed of the allegation on 8/15/2022 the nursing assistant #1 was immediately removed from the building and suspended pending investigation, investigation was initiated and the Initial Report for alleged abuse was submitted for resident #3. Nursing assistant #1 was terminated on 8/19/2022. 2. Starting on 8/16/2022 alert and oriented residents (BIMS >8) were interviewed to identify others that may have concerns regarding treatment by CNAs. Skin assessments were done for cognitively impaired residents (BIMS <8). Interviews and skin checks were completed 9/7/2022. 3. Regional Director of Clinical Services educated Administrator and Director of Nursing to remove the staff member that is identified in the allegation immediately. Completed on 8/16/2022. 4. Employees involved in allegations will be removed immediately upon knowledge of an investigation by the Administrator or Director of Nursing. Administrator will monitor weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 610	Continued From page 10	F 610		

She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call.

An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she received a call from Nurse #2 on 8/14/22 and she was informed that a family member and staff member was arguing back and forth. She stated she told Nurse #2 to send the staff member home. She stated the staff member also had called her and informed her that the family member was cursing at him and making threats to him, and she told him to go home and come back the next day and talk with management. She stated she sent him home because she did not want it to escalate. She indicated she was not aware of an allegation of mistreatment with Resident #3.

An interview was conducted on 8/15/22 at 5:49 pm with NA #1 and he indicated he was providing care for Resident #3 on 8/14/22 while the family member was present. He indicated during care he asked Resident #3 to stop being so aggressive so he could provide care for her. He indicated the family stated he looked a little frustrated and he to leave the room stated he left the room, and the family member followed him down the hall. He stated he then called the manager on call because the family member was yelling and cussing at him, and he was told by the Manager on call to go home and return to work the next day.

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F 610	Continued From page 11	F 610		

During this interview NA #1 indicated he was present in the dining room at the facility because he was told to come back to work at 2:00 pm on 8/15/22 and was working on the other side of the hallway and around 4:00 pm he was asked by the Director of Nursing to write a statement of what happened on Sunday. He stated he was not being aggressive with the resident and that the resident was aggressive at times and yells when care provided. He indicated it takes 2 people to help with Resident and he and another NA was providing care for Resident, and the other NA left the room briefly to get some soap.

An interview was conduct with the NA#5 on 08/15/22 at 6:10pm, she was asked by NA #1 to help provide care for Resident #3. NA #5 indicated she was not present during the entire time with NA #1 and the family. NA #5 stated NA #1 had already been in the room prior to asking her to help.

During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful.

Review of the alleged perpetrator's timecard revealed perpetrator had clocked in on 8/15/22 at 2:11 pm and clocked out at 6:01 pm.

During an interview with the Director of Nursing on 08/19/2022 at 11:41 am, she indicated her expectation was for staff to notify the abuse

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F 610	Continued From page 12 compliance officer who is the Administrator and/or herself of any allegations of abuse, and the alleged perpetrator would be suspended until the investigation was completed to make sure all residents are protected. During an interview with the Administrator on 8/19/2022 at 1:18 pm and it was indicated it appeared to a misunderstanding of the allegation. However, his expectation was suspend the alleged perpetrator pending investigation.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code a discharge and a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for facility discharge (Resident #98) and 1 of 1 resident reviewed for behaviors (Resident #3). The findings included: 1. Resident #98 was admitted to the facility 6/12/2022 with diagnoses to include hypertension and lung disease. Resident #98 left against medical advice (AMA) on 6/13/2022. The discharge MDS dated 6/13/2022 documented Resident #98 had an unplanned discharge to the hospital. A nursing note dated 6/13/2022 documented	F 641	1. Resident #98 discharge destination was corrected in the discharge MDS on 8/18/2022. Mood and behavior for resident #3 MDS was corrected on 9/1/2022. 2. Effective 8/24/2022 MDS nurses reviewed 30 days of discharge summaries to ensure accurate coding of discharge status, mood and behavior was coded correctly. Completed on 9/9/2022. No correction for discharge status and 3 corrections on mood and behavior. Corrections completed on 9/9/2022. 3. Effective 8/31/2022 & 9/1/2022 Regional MDS Consultant educated MDS nurses on coding MDS assessment accurately regarding discharged, mood, and behavior. The facility is in process of hiring a social service director, they will	9/14/22

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F 641	Continued From page 13 Resident #98 left the facility AMA with a family member. A social work note dated 6/13/2022 documented Resident #98 wanted to go home, and she called a family member and left AMA. An interview was conducted with the MDS nurse on 8/18/2022 at 11:34 AM. The MDS nurse reported she was not aware Resident #98 ' s MDS was coded as a hospital discharge. The Administrator was interviewed on 8/19/2022 at 10:11 AM. The Administrator reported when Resident #98 left the facility, she had said she was going back to the hospital. The Administrator reported he thought that was why the MDS nurse coded the assessment as Resident #98 was discharged to the hospital. The Administrator reported it was his expectation that MDS assessments were coded accurately, and errors were corrected. 2. Resident #3 was admitted to the facility on 04/28/22 with diagnoses of Dementia with behavioral disturbances and Alzheimer ' s disease. A review of care plan dated 5/3/22 and last revised on 7/15/22 revealed Resident #3 was resistive to care by exhibiting aggressive behaviors by biting, kicking, punching at staff, and screaming and yelling profanities. The goal was Resident would cooperate with care through next review. Interventions included staff were to give clear explanation of all care activities prior to an as they occur during each contact and make sure resident is safe, leave and reapproach resident once she is calm.	F 641	receive education from the MDS nurses to ensure the deficient practice will not recur. 4. Administrator and/or designee will audit 3 discharge assessments to ensure the proper discharge status is coded accurately weekly x 8 weeks. Administrator and/or designee will audit 3 MDS assessments to ensure the proper behaviors are coded accurately weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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F 641	Continued From page 14 Resident #3 ' s admission Minimum Date Set (MDS) dated 05/04/22 indicated Resident #3 had cognitive impairment and required extensive assistance with 2-person physical assist with bed mobility, dependent with 2-person physical assist with transfer, toilet use, extensive assistance of one-person physical assist with eating. No mood or behaviors coded on this MDS. On 8/19/22 at 10:46 am an observation was made of NA #2 and NA #4 attempted to provide activities of daily living care while Resident #3 was resistive to care. During an interview on 8/19/22 at 10:54 am with NA#2 it was indicated Resident #3 is like that all the time, fighting and resisting to let us care for her. NA #2 indicated they sometime come back later, but we just try and get it done.	F 641		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Physician Assistant and the Medical Director, the facility failed to implement an order from the hospital discharge summary to test blood sugar	F 684	1. Resident #72 no longer resides in the facility. 2. Regional Director of Clinical Services (RDCS) reviewed current residents with	9/14/22

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F 684	Continued From page 15 twice daily for Resident #72. The facility administered injectable and oral diabetes medication to Resident #72 who was diagnosed with diabetes without monitoring the resident's blood sugar from admission to the facility until admission to the hospital. On 8/13/22, Resident #72's blood sugar registered "HI" on the glucometer. Resident #72 was sent to the emergency department (ED) due to being lethargic and staff were unable to obtain vital signs. At the hospital, Resident #72 ' s blood sugar was recorded as 764 milligrams per deciliter (mg/dl) and the Resident received insulin via intravenous method to lower blood sugar levels. Resident #72 was diagnosed with Diabetic Ketoacidosis (a buildup of acids in your blood that can lead to diabetic coma or even death) /Hyperosmolar hyperglycemia (an extremely high blood sugar level). This deficient practice occurred for 1 of 3 sampled residents reviewed for diabetes care (Resident #72). Immediate jeopardy began on 4/21/22 when the facility failed to monitor blood sugars for Resident #72 who had diabetes and received injectable and oral diabetes medications. The hospital discharge summary included orders to monitor the resident ' s blood sugars twice a day. The facility admission orders did not include blood sugar monitoring twice daily. The immediate jeopardy was removed on 8/18/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced.	F 684	diabetic medication orders to ensure residents are receiving blood sugar checks for 30 days (7/18/2022 - 8/18/2022) of admissions to ensure accuracy of orders on 8/18/2022. 3. The Staff Development Coordinator, RDCS and Unit Managers educated the licensed nurses regarding the process for verifying new admission orders for residents admitted to the facility, ensuring a second nurse verifies orders for accuracy. New licensed nurses will receive this education in orientation. The RDCS educated the Director of Nursing and nurse managers regarding the validation of new admission orders during the morning clinical meeting for admissions from the prior day. All education was completed on 8/17/2022. 4. Director of Nursing and/designee will review new admission orders on the next business day for accuracy daily x 8 weeks. Director of Nursing will review 4 residents per unit receiving antidiabetic medications to ensure residents are receiving blood sugar checks as ordered by medical physician weekly x 8 weeks. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	

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The findings included:

A review of Resident #72 ' s hospital discharge (d/c) summary dated 4/17/2022 revealed orders to test blood sugar twice daily.

Resident #72 was admitted to the facility on 4/21/22 and had diagnoses including diabetes mellitus type 2, Parkinson ' s disease, and dementia.

Physician orders dated 4/21/22 included Trulicity (an antihyperglycemic injectable medication used to control high blood sugar) 1.5 milligrams (mg)/0.5 milliliters (ml) subcutaneously in the morning every Monday and Metformin HCl (an oral diabetes medication) 1000 mg give 1 tablet by mouth one time a day. Nurse # 1 documented the admission orders.

A review of Physician orders from 4/21/2022 through 8/13/2022 revealed no order documented for blood sugar monitoring.

During an interview on 8/17/22 at 2:08 pm with Nurse #1 it was indicated she was not completely sure if she had put the orders in the computer from the hospital d/c summary on admission, however she indicated she was the nurse that day. She indicated if it was documented on the discharge summary for Resident #72 to have blood sugar checks done that then there should have been an order to do so.

The Quarterly Minimum Data Set (MDS) dated 7/21/22 revealed resident had cognitive impairment received insulin during the assessment period.

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A review of Physician progress notes dated 4/27/22, 5/26/22, 6/23/22 read, in part, recent A1c (A blood test that measures your average blood sugar levels over the past three months.) was 6.6% (A level of 6.5% indicates diabetes.) and will check blood sugars before meals and at bedtime.

A review of medical record revealed blood sugar was obtained after a fall on 4/29/22 and was 88 mg/dl.

A review of the Basic Metabolic Panel dated 5/16/22 revealed the sugar result was high at 220 mg/dl, reference range is 70-99 mg/dl.

A review of medical record revealed a blood sugar was obtained on 6/23/22 and was 155 mg/dl.

A review of a Progress notes by Nurse #2 dated 8/13/22 read, in part, Resident #72 was found to be severely lethargic, skin cool to touch and staff were unable to obtain vital signs. Blood sugar registered "HI", which per the glucometer manufacture information indicates a result of HI is over 600 mg/dl. Spouse was present & agreed with nurse to transfer Resident to hospital ED for evaluation and treatment. Call was placed to on-call Nurse Practitioner and was made aware. A call was placed to 911 to transfer Resident to hospital and emergency medical service arrived and transferred resident to hospital.

An interview with Director of Nursing (DON) 8/17/22 at 3:05 pm was conducted and she indicated she was not aware Resident #72 had orders on admission for blood sugar checks. She stated the facility should have verified the orders for the blood sugar checks

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On 8/17/22 at 3:19 pm an interview with Physician Assistant who indicated an order for blood sugar checks was missed by her and the Physician. She indicated if blood sugar checking was on the orders from the hospital, then the blood sugar should have been checked as ordered.

During an interview with the Medical Director (MD) on 8/18/22 at 4:49 pm it was indicated the facility had issues with orders that were not being transcribed as ordered. He indicated for Resident #72 the blood sugar checks were missed and the facility should have been doing the checks as they were ordered. He indicated if the facility had been doing the blood sugar checks, then staff could ' ve seen his blood sugar was rising ahead of time and modified his medications.

A review of the EMS report dated 8/13/22 at 7:48 pm revealed upon arrival to facility Resident #72 was responsive to verbal stimuli by name only and blood sugar was obtained, and results read "HI".
According to the hospital ED documentation dated 8/13/22, Resident #72 had a blood sugar of 764 mg/dl in the ED and was diagnosed with Diabetic Ketoacidosis/Hyperosmolar hyperglycemia and remained in the hospital at the time of the survey. The Resident presented to the ED with altered mental status and was admitted for further management. He was started on an insulin drip for severe hyperglycemia.

The Administrator was notified of immediate jeopardy on 8/17/22 at 5:06 pm.

On 8/18/2022 the facility provided the following

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credible allegation of Immediate Jeopardy removal:
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to complete an evaluation of residents #72 medication regimen that identified the need to monitor insulin administration and anti-diabetic medications. Resident #72 medication regimen review did not identify the inadequate monitoring of insulin administration and anti-diabetic medication. Resident #72 received weekly insulin and daily anti-diabetic medication without blood sugar testing as ordered and experienced critically high blood sugars identified at the hospital. A review of the pharmacy medication regimen reviews for the months of April, May, June, and July of 2022 revealed no identification of inadequate monitoring of insulin administration and anti-diabetic medication.

On 8/17/2022 the Regional Director of Clinical Services (RDCS), reviewed residents with diabetic medication to ensure residents are receiving blood sugar checks. On 8/17/22 the RDCS notified the Nurse Managers of any opportunities identified during this audit and explained their responsibility to correct by 8/17/2022. On 8/17/2022 the Regional Director of Clinical Service (RDCS), reviewed 30 days of admissions to ensure accuracy of orders.

Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed.

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The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers educated the Licensed Nurses regarding the process for verifying new admission orders for residents admitted to the facility. The nurse is to call the medical doctor and/or nurse practitioner to verify orders on the discharge summary prior to entering the orders into the residents ' electronic medical record. When the admission orders are entered into the electronic medical record, a second nurse is to verify orders for accuracy when confirming. The Director of Nursing will ensure no licensed nurse will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 8/17/2022 by the Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers.

The Regional Director of Clinical Services educated the Director of Nursing and Nurse Managers regarding the validation of new admission orders during the morning clinical meeting for admissions from the prior day. This education was completed on 8/17/2022.

Effective 8/17/2022 the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance

Alleged Date of Immediate Jeopardy Removal: 8/18/2022

On 8/19/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed.

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Interview with the Regional Clinical Nurse Consultant revealed when a new admission was admitted to the facility, the nurse needed to call the Medical Director or Nurse Practitioner to verify discharge summary orders prior to entering the orders into the resident ' s medical record. She also indicated when admission orders were placed in the medical record, a second nurse was to verify orders when confirming for accuracy, and when the resident entered the facility, they were to take the discharge summary from the resident and verify the orders that were in the system for accuracy.

A review of the audits revealed all residents ' orders were reviewed and any discrepancies were corrected.

A review of the education training revealed education was provided to staff as stated in the credible allegation.

Interview was conducted with staff on 8/19/2022 at 10:52 am who indicated knowledge of what to do for new admission residents and entering the new orders.

Interview was conducted with staff on 8/19/2022 at 11:00 am who indicated knowledge of what to do for new admission residents and entering the new orders from the hospital.

Interview was conducted with Unit Manager on 8/19/2022 at 11:45 am who indicated knowledge of the process implemented to verify orders from the d/c summary from the hospital for all new patients.
Interview was conducted with Staff Development Coordinator on 8/19/2022 at 11:58 am and it was

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F 684	Continued From page 22 indicated she had the knowledge of how to complete the medication reconciliation for new admissions, and she also indicated a new checklist that was implemented for the completion of new admissions. Interview with the DON on 8/19/2022 at 12:00 pm revealed the new admission audit will help the nurses complete a full assessment of residents ' needs. All medications and treatments will be reviewed for the residents during the admission process. Interviews with staff revealed that education was provided. The immediate jeopardy removal date of 8/18/2022 was validated.	F 684		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and the staff interviews the facility failed to have a Registered Nurse	F 727	1. Staff schedules were adjusted immediately to ensure proper RN	9/14/22

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F 727	Continued From page 23 scheduled for 8 consecutive hours a day for 1 (07/25/22) of 30 days reviewed. Findings included: A review of the Nursing schedule dated 07/18/22 through 08/18/22 revealed no scheduled Registered Nurse on 07/25/22. Review of the timecards revealed the facility had no documentation of a RN present in the facility on 07/25/22 to meet the requirement for an RN at least 8 consecutive hours per day on 07/25/22. An interview conducted with the Scheduler on 08/18/22 at 9:30am stated there should have been a Registered Nurse scheduled on 07/25/22. The Scheduler stated she worked with staff agencies to ensure RN coverage. An interview conducted with the Director of Nursing on 08/18/22 at 11:30am stated she expected the facility to have a Registered Nurse staffed to meet the regulation for 8 consecutive hours a day, 7 days a week. An interview conducted with the Administrator on 08/18/22 at 2:30pm stated he expected the Scheduler to staff a Registered Nurse for 8 hours per day, 7 days a week.	F 727	coverage is in place. 2. Current residents are affected by this current deficiency. 3. Regional Director of Clinical Services educated the Director of Nursing and Administrator on 8/31/2022 on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week. 4. Director of Nursing and/or designee will audit schedule to ensure a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 756 SS=K	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.	F 756		9/14/22

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F 756	Continued From page 24 §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 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, Consultant Pharmacist, Medical Director and staff interviews, the facility failed to complete an evaluation of Resident #72's medication regimen that identified the need to monitor injectable and oral diabetes medications	F 756	1. Resident #72 no longer resides in the facility. 2. Regional Director of Clinical Services (RDCS), reviewed residents with diabetic medication, pharmacy medication	

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F 756	Continued From page 25 for 4 of 4 medication regimen reviews. Resident #72 received weekly injectable and daily oral diabetes medication without blood sugar testing as ordered and experienced critically high blood sugars identified at the hospital. This deficient practice occurred for 1 of 6 sampled residents reviewed for medication regimen review (Resident #72). Immediate Jeopardy began on 4/27/22 when the facility failed to complete an evaluation of Resident #72 ' s medication regimen that identified the need to monitor injectable and oral diabetes medications and failed to identify the inadequate monitoring of injectable and oral diabetes medication as ordered to test blood sugar tests twice daily. The Immediate Jeopardy was removed on 8/19/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The findings included: A review of Resident #72 ' s hospital discharge (d/c) summary dated 4/17/2022 revealed orders to test blood sugar twice daily. Resident #72 was admitted to the facility on 4/21/22 and had diagnoses including diabetes mellitus type 2, Parkinson ' s disease, and dementia. The Quarterly Minimum Data Set (MDS) dated 7/21/22 revealed resident had cognitive	F 756	regimen reviews for the months of April, May, June, and July of 2022 to ensure residents have been reviewed for orders that were not transcribed from the discharge summary to the resident's medical record, to ensure residents that are receiving diabetic medication has blood sugar checks and address any concerns and nurse management reviewed 30 days of admissions to ensure accuracy of transcribing medications from the discharge summary to the residents' medical records on 8/18/2022. 3. The Regional Director of Clinical Services educated the facility pharmacist on reviewing the resident's admission orders to ensure orders from the discharge summaries are implemented as ordered, as well as diabetics that are reviewed monthly to identify any monitoring of blood glucose checks for resident insulin and/or anti-diabetic medications. This education was completed on 8/18/2022. Education will be provided to the new pharmacist if the facility has a change by the Regional Director of Clinical Services (RDCS). 4. Effective 8/18/2022 the Regional Director of Clinical Services will review the pharmacy monthly medication regimen on new admissions for 2 months to ensure accuracy from the discharge summary to include medications and interventions. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	

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impairment received insulin during the assessment period.

Review of physician orders revealed orders dated 4/21/22 included Trulicity (an antihyperglycemic injectable medication used to control high blood sugar) 1.5 milligrams (mg)/0.5 milliliters (ml) subcutaneously in the morning every Monday and Metformin HCl (an oral diabetes medication) 1000 mg give 1 tablet by mouth one time a day. Nurse # 1 documented the admission orders. No order documented for blood sugar monitoring. Manufacturer precautions for Trulicity and Metformin indicate "Check blood glucose levels regularly."

A review of pharmacy medication regimen review for the month of April dated 4/27/2022 by Pharmacist #1 revealed a review of Resident #72 ' s medical record which included discharge summary, vital signs, weight, labs, progress notes, Physician/Nurse Practitioner notes were done, and no recommendations were made related to blood sugar monitoring.

A review of pharmacy medication regimen review for the month of May dated 5/27/22 by Pharmacist #1 revealed a review of Resident #72 ' s blood sugar dated 4/29/22 was 88 mg/dl and no recommendations were made related to blood sugar monitoring.

A review of pharmacy medication regimen review for the month of June dated 6/28/22 by Pharmacist #2 revealed a review was completed of Resident #72 ' s medical record including: orders, available labs, progress notes and no recommendations were made related to blood sugar monitoring.

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A review of pharmacy medication regimen review for the month of July dated 7/18/22 by Pharmacist #2 revealed a review was completed for Resident # 72 ' s medical record including: orders, available labs, progress notes and no recommendation were made related to blood sugar monitoring.

A review of Progress note dated 8/13/22 read, in part, Resident #72 was found to be severely lethargic, skin cool to touch and staff were unable to obtain vital signs. Blood sugar registered "HI". (The glucometer manufacturer ' s information indicates "HI" displays if the result is over 600 mg/dl.) Spouse was present and agreed with nurse to transfer Resident to hospital emergency department (ED) for evaluation & treatment Call placed to 911 and Resident transferred to ED by emergency medical services.

According to the review of hospital ED documentation dated 8/13/22, Resident #72 had a blood sugar of 764 milligrams per deciliter (mg/dl) in the ED and was diagnosed with Diabetic Ketoacidosis (a buildup of acids in your blood that can lead to diabetic coma or even death) /Hyperosmolar hyperglycemia (an extremely high blood sugar level) and remained in the hospital at the time of the survey. The Resident presented to the ED with altered mental status and was admitted for further management. He was started on an insulin drip for severe hyperglycemia.

On 8/18/2022 at 9:35 am an interview was conducted with Pharmacist #1, and she indicated she was no longer the Pharmacy consultant for the facility, however, was for the months of April

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and May 2022. She stated she was not able to see any documentation for Resident #72 due to no longer having access to the facility records, however she stated in general she would look at the d/c summary and the orders in the computer that the Nurse entered in the computer. She indicated it was usually the facility ' s protocol to verify orders with the Physician and then enter the orders in the computer. She stated it was her understanding that the orders in the system were accurate. She indicated residents that have the diagnosis of diabetes would not necessarily have blood sugars monitored daily, but she would rather review their A1c because it was a more accurate marker of how residents ' diabetes are controlled verses a blood sugar check that can fluctuate. She indicated if the resident would have had an incident that would warrant her to recommend blood sugar checks, then she would have recommended it to be done.

During an interview on 8/18/2022 at 11:50 am with Pharmacist #2, it was indicated she noted from the Physicians June progress note that Resident #72 had a recent A1c of 6.6%, and June fingerstick blood sugar was 155, which indicated to her a stable blood sugar. She indicated Resident #72 had no issues whatsoever and was a stable diabetic from what she reviewed starting in June 2022. She also indicated Resident had no previous concerns by the other Pharmacist. She indicated she wasn ' t concerned and had in her notes to follow-up with another A1c in September 2022, which she indicated was 3 months from the June Physician progress note with the 6.6 % A1c result. She stated when she last reviewed Resident #72 ' s medications he was a stable diabetic with no signs of diabetic issues. She indicated she reviewed Resident #72

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' s medications on 8/18/2022 and noted Resident had started Megace (ordered for an appetite stimulant) on 8/8/22 and it could have possibly been the cause of his blood sugar to have increased. She stated Trulicity and Metformin are not medications that need blood sugar monitoring, and she would not have known the Resident had orders on admission for blood sugar monitoring as she was not the Pharmacist for the facility at the time of his admission.

During an interview with the Medical Director (MD) on 8/18/22 at 4:49 pm it was indicated the facility had issues with orders that were not being transcribed as ordered. He indicated for Resident #72 the blood sugar checks were missed and the facility should have been doing the checks as they were ordered. He indicated if the facility had been doing the blood sugar checks, then staff could ' ve seen his blood sugar was rising ahead of time and modified his medications.

The Administrator was notified of immediate jeopardy on 8/18/2022 at 1:22 pm.

The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance.

The facility failed to complete an evaluation of residents #72 medication regimen that identified the need to monitor insulin administration and anti-diabetic medications. Resident #72 medication regimen review did not identify the inadequate monitoring of insulin administration and anti-diabetic medication. Resident #72 received weekly insulin and daily anti-diabetic

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medication without blood sugar testing as ordered and experienced critically high blood sugars identified at the hospital. A review of the pharmacy medication regimen reviews for the months of April, May, June, and July of 2022 revealed no identification of inadequate monitoring of insulin administration and anti-diabetic medication.

On 8/18/2022 the Regional Director of Clinical Services (RDCS), reviewed residents with diabetic medication pharmacy medication regimen reviews for the months of April, May, June, and July of 2022 to ensure residents have been reviewed for orders that were not transcribed from the discharge summary to the resident ' s medical record, to ensure residents that are receiving diabetic medication has blood sugar checks and address any concerns. Pharmacy medication regimen reviews did not include the discharge summaries.

On 8/18/2022, nurse management reviewed 30 days of admissions to ensure accuracy of transcribing medications from the discharge summary to the residents ' medical records. Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed.

The Regional Director of Clinical Services educated the facility pharmacist on reviewing the resident ' s admission orders to ensure orders from the discharge summaries are implemented as ordered, as well as diabetics that are reviewed monthly to identify any monitoring of blood glucose checks for resident insulin and/or anti-diabetic medications. This education was

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F 756	Continued From page 31 completed on 8/18/2022. Education will be provided to the new pharmacist if the facility has a change by the Regional Director of Clinical Services (RDCS). Effective 8/18/2022 the Regional Director of Clinical Services will review the pharmacy monthly medication regimen on new admissions for 3 months to ensure accuracy from the discharge summary to include medications and interventions. Effective 8/18/2022 the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of Immediate Jeopardy Removal: 8/19/2022 On 8/19/22 the credible allegation of immediate jeopardy was validated by onsite verification which included record reviews and interviews which verified the audits and education were completed. An interview with the Regional Clinical Nurse Consultant revealed they will review the pharmacy monthly medication regimens on new admissions for 3 months to ensure accuracy of orders from the discharge summary to include medications and interventions. The facility's immediate jeopardy removal date of 8/19/2022 was validated on 8/19/2022.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/14/22

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F 812	Continued From page 32 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units. The findings included: An initial tour of the kitchen was made on 8/15/22 at 10:40 AM with the Cook. The following observations were made in the walk-in cooler: 1. ½ container of 1 gallon of honey mustard dressing with no date with two dots of black substance on the inside of the container. 2. 1 gallon of opened sweet pickle relish dated 1/31/22. The following observations were made in the	F 812	1. 1. Food items were discarded immediately upon notification on 8/15/2022. 2. Effective 8/25/2022 the Dietary Manager inspected the walk-in and Reach-in refrigerators to ensure appropriate labels and dates were indicated on opened items. 3. Dietary Manager educated staff on appropriate labeling, dating, and discarding food items that are out of date on 8/17/2022. 4. Dietary manager will inspect walk-in and reach-in refrigerators for proper storage and labeling weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues	

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F 812	Continued From page 33 reach-in refrigerator: 1. ½ a container of 1 quart of prune juice with an open date of 4/28/22. 2. 46 fluid ounces (fl. oz.) of opened thickened apple juice with a date of 7/28/22 with no open date. Manufacturer's guidelines stated to keep in refrigerator up to 7 days after opening. 3. 32 fl. oz. of opened thickened dairy drink with a date of 6/27/22 with no open date. Manufacturer's guidelines stated to keep in refrigerator up to 7 days after opening. During the observations on 8/15/22 at 11:05 AM the Cook stated that the date on the thickened liquids was the date the item came into the kitchen but should have had an open date. Based on the open date, the items should be tossed after three days. An interview with Dietary Aide #1 on 8/15/22 at 11:07 AM stated that items should have a date labeled of when it came into the kitchen, but it would not have been labeled with an open date. An interview with Dietary Aide #2 on 8/15/22 at 11:09 AM stated that items should have a date labeled of when it came into the kitchen, and items should be labeled with the date the item was opened. During a follow-up visit to the kitchen on 8/17/22 at 11:30 AM the Dietary Manager stated that the prune juice was labeled incorrectly, the date of 4/28/22 was the date that it came into the kitchen, not the date it was opened. A second interview with the Dietary Manager on	F 812	identified are corrected.	

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F 812	Continued From page 34 8/18/22 at 2:40 PM stated that she expected that once a food item was opened, staff would get a marker and put an open date on it and label what the item was. An interview was completed with the Administrator on 8/19/22 at 10:20 AM who stated that foods should be labeled when opened and to dispose of items when they are expired.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure the area around the dumpster was free of debris for 2 of 2 dumpsters. The findings included: During an observation of the dumpster area on 8/17/22 at 10:45 AM accompanied by the Dietary Manager (DM). The observation revealed a gray utility tilt cart in between the two dumpsters. The gray utility tilt cart had standing water inside the cart and on the inside of the cart was several pieces of wet cardboard which was stuck to the tilted part of the cart (which empties the trash). The ground area behind the gray utility tilt cart and in between the two dumpsters was littered with garbage lying in the pine needles which included cardboard, bunched up plastic wrap, cigarette butts, cigarette package, used masks and plastic gloves and soda cans and plastic soda bottles.	F 814	1. Items around the dumpster were cleaned up on 8/17/2022. 2. On 8/17/2022, Administrator inspected the area around the dumpster is free if debris. 3. On 8/31/2022 Maintenance, housekeeping and dining services were educated by the Administrator or designee on the importance of keeping the dumpster area free of debris and covers closed. 4. Maintenance will monitor and maintain cleanliness around the dumpster Monday-Friday at the beginning and end of workday. Dining services will monitor and maintain cleanliness around the dumpster on the weekends. Administrator will inspect the area around the dumpsters, weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.	9/14/22

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F 814	Continued From page 35 During the observation with the DM on 8/17/22 at 10:45 AM she stated that the gray utility cart had belonged to the housekeeping department and the dumpster area was a shared responsibility between the kitchen and housekeeping with maintaining the area. The DM stated that she had spoken to the Housekeeping Manager (HM) on 8/16/22 and offered to clean the area up with the HM however, the HM was short staffed and had been working on the floor on 8/16/22. A follow up telephone interview on 8/18/22 at 2:40 PM with the DM who stated that when staff would take out the garbage they should check the dumpsters doors, if they are open, they should shut them and if any garbage is on the ground they are to where gloves and should have picked up the garbage. A telephone interview was completed with the HM on 8/18/22 at 3:02 PM who stated that when staff take out the garbage to the dumpster area they should pick up and garbage on the ground. An interview was completed with the Administrator on 8/19/22 at 10:20 AM who stated that when the dumpsters were emptied garbage could fall out from the dumpsters. The Administrator stated the Maintenance Manager had just cleaned the area last week. The Administrator explained we would not want garbage lying around as this was people's homes.	F 814	Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		9/14/22

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	345116	A. BUILDING _____ B. WING _____	C 08/19/2022

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F 867	Continued From page 36 §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 observation, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following recertification and complaint survey conducted on 11/01/2019. This was for 1 deficiency that was cited in the areas of Resident Assessment/Accuracy of Assessment. And cited on again recertification and complaint survey on 12/16/21 and on the current recertification and complaint survey 08/19/22. The QAA committee additionally failed to maintain implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 12/16/21. This was evident for 2 deficiencies that was cited in the areas of Quality of Care and Nursing Services and recited on the current recertification and complaint survey of 08/19/22. The QAA additionally failed to maintain implemented procedures and monitor intervention the committee put in place following complaint investigation on 02/05/21. This was evident of 1 deficiency in the area of Food and Nutrition Services: Food Procurement, Store/Prepare/Service- Sanitary and recited on the current recertification and complaint survey on 08/19/22. The duplicate citations during the four federal surveys of record shows a pattern of the facility's inability to sustain and effective QAA program	F 867	1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F641, F684, F727, and F812 on 9/1/2022. 2. Current residents are potentially affected by this deficiency. 3. The Regional Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F641, F684, F727, and F812 on 9/1/2022. 4. On 9/1/2022, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Unit Support Nurse, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will	

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F 867	Continued From page 37 Findings included: This tag is cross reference to: 1.F641: Based on record reviews and staff interviews, the facility failed to accurately code a discharge and a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for facility discharge (Resident #98) and 1 of 1 resident reviewed for behaviors (Resident #30). During the recertification and complaint survey on-11/01/19, the facility failed to accurately code Section K-Swallowing/Nutritional Status of the Minimum Data Set (MDS) assessments for 1 of 6 sampled residents reviewed for Nutrition. During recertification and complaint survey on 12/16/21, the facility failed to accurately code the Minimum Data Set (MDS) for opiate medication for 1 of 24 residents reviewed for MDS. 2. F- 684: Based on record review and interviews with staff, Physician Assistant and the Medical Director, the facility failed to implement an order from the hospital discharge summary to test blood sugar twice daily for Resident #72. The facility administered injectable and oral diabetes medication to Resident #72 who was diagnosed with diabetes without monitoring the resident's blood sugar from admission to the facility until admission to the hospital. On 8/13/22, Resident #72's blood sugar registered "HI" on the glucometer. Resident #72 was sent to the emergency department (ED) due to being lethargic and staff were unable to obtain vital signs. At the hospital, Resident #72 ' s blood sugar was recorded as 764 milligrams per deciliter (mg/dl) and the Resident received insulin	F 867	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. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. 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.	

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F 867	Continued From page 38	F 867		

via intravenous method to lower blood sugar levels. Resident #72 was diagnosed with Diabetic Ketoacidosis (a buildup of acids in your blood that can lead to diabetic coma or even death) /Hyperosmolar hyperglycemia (an extremely high blood sugar level). This deficient practice occurred for 1 of 3 sampled residents reviewed for diabetes care (Resident #72).

During the recertification and complaint survey on 12/16/21, the facility failed to consistently complete wound care as ordered for 2 of 2 sampled residents.

3.727: Based on record reviews and the staff interviews the facility failed to have a Registered Nurse scheduled for 8 consecutive hours a day for 1 (07/25/22) of 30 days reviewed.
During the recertification and complaint survey on 12/16/21, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 7 of 31 days.

4. F 812: Based on observations, record review and staff interviews, the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units.

During a complaint investigation survey on 02/05/21, the facility failed to maintain the temperatures of hot foods being served from the kitchen's steam table at 135 degrees Fahrenheit (F.) or higher for five of five resident meals that were observed being prepared from the steam table.

An interview with the Administrator was

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F 867	Continued From page 39 conducted on 08/19/22 at 2:35 pm, he revealed that his expectation was for the team to work together to sustain an effective QAPI Committee to ensure the facility does not recite a previous deficient practice. Administrator indicated that this was his goal that the facility does not received any more repeat tags	F 867		