STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING ______ B. WING ______	C 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 2/7/2023 through 2/10/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LKM011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 2/7/2023 through 2/10/2023. Event ID# LKM011. The following intakes were investigated NC00196256, NC00196455, NC00196628, NC00196720, and NC00197385. One of ten complaint allegations resulted in a deficiency.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interview the facility failed to provide a resident, that was cognitively able to use a call bell, with a specialty call bell or way to call for assistance without having to yell for 1 of 1 resident reviewed for accommodation of needs (Resident #87). The findings included: Resident #87 was admitted to the facility on 01/22/21 and recently readmitted to the facility on	F 558	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ On 2/9/23 resident #87 was provided with a flat call bell placed behind resident's left shoulder. A therapy referral was presented to the therapy department to screen resident for call bell use. On 2/17/23 Occupational Therapy provided resident #87 with a breath activated call light to improve ability to convey	3/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/06/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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01/02/23.

Review of the quarterly Minimum Data Set (MDS) dated 01/13/23 indicated that Resident #87 was severely cognitively impaired for daily decision making and required total assistance from staff for activities of daily living. The MDS further indicated that Resident #87 had an impairment to one upper and lower extremity and had a tracheostomy. The MDS further revealed that Resident #87 was able to understand others and was able to make his needs known.

Review of Resident #87's care plan on 02/07/23 revealed no care plan for how Resident #87 was to call for assistance.

An observation and interview were conducted with Resident #87 on 02/07/23 at 10:18 AM. Resident #87 was resting in bed with his eyes open. He stated that he needed to be suctioned. Resident #87's nurse was summoned to suction him as he requested. Above Resident #87's bed was a plaque on the wall where a call bell would be attached. There was no call bell attached instead there were two plugs one in each outlet, but no call cord or bell was attached. He stated that he would holler at staff as they walked by his room when he needed assistance. Resident #87 stated that he was paralyzed and could not move around very much. Resident #87 stated that he had a call bell that was flat like a pancake about a year ago and he was not sure why he did not have one now or what happened to the flat call bell.

An observation and interview were conducted with Resident #87 on 02/08/23 at 5:31 PM. Resident #87 was resting in bed with his eyes

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wants/needs. Resident was able to demonstrate success in activating call light on command. Therapy also facilitated application and training of the breath activated call light to improve ability to convey wants/needs for the nursing department. This education was completed on 2/17/23. Resident's care plan was updated with breath activated call light for communication on 2/17/23 by the Minimum Data Set Coordinator.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿All residents have the potential to be affected by this alleged deficient practice, therefore on 2/10/23 a 100 audit was conducted by the Maintenance and Activities Directors on each resident room to verify that each resident had a call light or an effective device in place for communication. No other residents were identified.

3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
The Administrator educated the interdisciplinary team while completing their daily ambassador rounds 5 days per week Monday through Friday to verify that each resident has a call light or appropriate communication device in place to communicate their needs. Report

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open. The plaque above his bed on the wall where a call bell would be attached, again was noted to have two plugs one in the outlet with no call cord or bell attached to it. Resident #87 stated that when he had his flat call bell he could not use it by pressing it with his hands but could use his head to press and activate the call light. He again stated that if he needed something he just tried to holler at the staff as they walked by his room. Resident #87 stated that at times the staff came right in when he hollered.

Nurse Aide (NA) #4 was interviewed on 02/08/23 at 5:35 PM and confirmed that she cared for Resident #87 regularly. She stated that when he needed something he would yell at the staff out in the hallway. She stated that Resident #87 had just yelled out because he was wanted his dinner tray. NA #4 stated that since she had been caring for Resident #87, he has always yelled at the staff to get their attention and had not used a call bell.

An interview was conducted with NA #5 on 02/09/23 at 2:31 PM who stated she routinely cared for Resident #87. She stated that when Resident #87 needed something he would yell at the staff in the hallway. She stated he usually wanted food or be suctioned. NA #5 stated that she had seen Resident #87 with a call bell before but could not recall if he used it or not or if was flat or not.

An observation of Resident #87 was made on 02/09/23 at 2:53 PM. Resident #87 was resting in bed with his eyes closed. The plaque above his bed on the wall contained two plugs one in each outlet with no call cord or call bell attached.

The Wound Nurse (WN) was interviewed on

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findings daily during morning meetings. The weekend manager on Saturday and Sunday will audit 5 residents per day to verify a call light or communication device is in place to communicate their needs and report findings to the administrator. Education was completed on 3/6/23. Facility Staff was educated to report to the administrator if a resident does not have a call light in place or a way to communicate needs and to also place in the maintenance Director communication binder. Education was provided by the Staff development coordinator. Nursing is to complete a therapy referral if a resident is unable to use a call light. Education was completed by March 6,2023. Staff will not be permitted to work until education is complete. Any new staff hired will be educated during orientation.

4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
As of 3/16/2023 The administrator and/or nurse management will ensure that each resident has an effective way to communicate. Audit 6 resident rooms 5xper week including weekends for 4 weeks; 3xper week including weekends x4 weeks; and 1x per week for 4 weeks; to verify that each resident has a call light and/or an appropriate device in place to communicate needs. The result of the audit will be reported by the Director of nursing to the Quality assurance and Performance improvement Committee monthly x3 months or until substantial compliance is achieved and maintained.

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02/09/23 at 3:15 PM and stated that she was very familiar with Resident #87. She stated he was paralyzed from the breastbone down. She stated that when he needed something he would yell for the staff in the hallway. She stated she did not think he could use a traditional call bell.

An interview was conducted with the Occupational Therapist (OT) on 02/09/23 at 4:42 PM. She stated that she last treated Resident #87 in July 2022 and at that time he had some use of both of his upper extremities and had enough strength to activate a flat call bell. The OT stated that Resident #87 had the cognitively ability to remember how to use it and when to use it. She was unaware that he did not have a call bell or way to call for assistance. The OT added that he could move his head side to side and a flat call bell would certainly be appropriate for him.

The Regional Nurse Consultant was interviewed on 02/09/23 at 4:50 PM who stated that she had placed a flat call bell behind Resident #87's left shoulder on 02/09/23 but she was not sure he could use it. She stated she was headed to therapy department to put a referral in for therapy to evaluate him to see if they could help him get some strength back to use the call bell. The Regional Nurse Consultant agreed that Resident #87 had the cognitive ability to use the call bell.

An observation and interview were conducted with Resident #87 on 02/09/23 at 4:52 PM. His call light was observed to be on in the hallway. He stated that he did not need anything but was seeing if he could turn the call light on with his shoulder. The light was turned off and again Resident #87 activated the call bell with his left shoulder and again he stated he was just making

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F 558	Continued From page 4 sure he could turn it on. The Director of Nursing (DON) and Administrator were interviewed on 02/10/23 at 2:08 PM. The Administrator stated that the management team would determine if a call bell was appropriate for each resident. He stated that Resident #87 communicated verbally and anytime he requested something he would yell to the staff in the hallway. The DON and Administrator were unaware of any previous device that had been in use by Resident #87. The DON stated, "it was well known that he yells for assistance."	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		3/10/23

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(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on a Resident Council Meeting, resident and staff interviews, and record review, the facility failed to resolve residents' complaints of food being served cold, which were discussed for 3 of 3 months during Resident Council Food Committee meetings, (November 2022, December 2022, and January 2023).

The findings included:

Resident Council Food Committee meeting minutes for November 2022, December 2022 and January 2023 documented residents expressed concerns about food temperatures, stating that once trays were delivered to the halls the meal trays remained on the halls for several minutes before delivery to residents and as a result, the food was served cold. The Certified Dietary Manager recorded in the minutes for each of these months that this concern would be addressed with nursing.

A Resident Council Meeting was held on 2/8/23 at 3:30 PM with 9 residents who regularly attended Resident Council meetings. During the meeting,

F 565

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿
As of 3-3-2023 the administrator has reviewed and addressed concerns for resident council food committee minutes for the months of November 2022, December 2022 and January 2023 regarding cold food complaints. As of 3-3-2023 residents #27, #68, #6, and #36 are receiving meals timely and at correct temperatures from dietary and nursing.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿
All residents have the potential to be affected by this deficient practice, therefore on 3-6-2023 a 100% audit of all residents with BIMs of 9 or higher have been interviewed regarding receiving cold food. As of 3-3-2023 administrator reviewed all resident council food committee minutes for the months of

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all 9 of the residents in attendance stated that they voiced concerns related to receiving cold food in the last 3 Resident Council Food Committee meetings, and they continued to receive foods served cold.

During the 2/8/23 Resident Council meeting, Resident #27 stated he had to wait at least 30 minutes to get assistance with his meals and by the time he ate, his food was cold. He stated this occurred as recently as last week. He further stated that he did not like the taste of reheated food.

Resident #68 stated during the 2/8/23 Resident Council meeting, that when the food carts were delivered to the units, the meal trays sat on the halls for a while before staff delivered the trays which caused her food to be cold once it was delivered. Resident #68 stated that if she asked to have her food reheated, staff told her that the microwave did not work.

Resident #6 stated during the 2/8/23 Resident Council meeting, that when she received cold food, and asked to have her meal reheated, staff told her they did not have time to heat up her food. Resident #6 stated this occurred at the breakfast and lunch meals that day.

Resident #36 stated during the 2/8/23 Resident Council meeting, that she received cold food for all 3 meals last week.

Nurse #1 stated in an interview on 2/9/23 at 3:57 PM that dietary staff announced to nursing staff when meal trays were delivered to the hall. At times, meal delivery to residents was delayed if nursing staff were providing nursing care when

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November 2022, December 2022, January 2023, and February 2023.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
As of 3-6-2023 all facility staff have been re-educated by the Director of Nursing (DON)/Nursing Supervisor on facility policy for serving meals at proper temperature i.e... Cold food cold and hot foods hot. As of 3/13/2023 DON/Administrator/Nurse Manager will monitor four trays per meal daily for 4 weeks, then five trays daily for 4 weeks and 1 tray daily for 4 weeks to ensure hot foods hot and cold foods cold. The administrator will review resident council minutes monthly and address concerns with written response.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:¿¿
The DON will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan.

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F 565	Continued From page 7 trays were delivered. Nurse #1 stated Resident #27 required staff assistance with meals and once staff delivered meal trays it then took about 5 minutes for staff to start assisting residents with their meals. Nurse #1 also stated that more staff were hired recently and that he felt this would help. The Certified Dietary Manager stated in an interview on 2/10/23 at 9:45 AM that residents expressed a concern with receiving cold food during the last 3 Resident Council Food Committee meetings and each time she brought it to the attention of the nursing department during morning meetings. The CDM stated that residents expressed that the meal carts sat on the halls for a while before being passed out. The CDM stated that she had not conducted a test tray but continued to monitor the food temperatures before the meal trays left the kitchen and the foods were hot. The Administrator was interviewed on 2/10/23 at 11:30 AM and stated that he was aware that residents had expressed food concerns in the last 3 Resident Council Food Committee meetings. He stated that each time, staff were re-educated, and staff were expected to monitor meal delivery to residents. The Administrator stated that he was uncertain if the complaints were from the same residents or if these were continued concerns expressed by new residents. He stated that he expected to see improvement in this concern because of a recent increase in the number of staff hired.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		3/10/23

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the

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F 578	Continued From page 9 appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have advance directive information available in the medication record for 2 of 3 residents reviewed for advance directives (Resident #212 and Resident #213). The findings included: 1. Resident #212 was admitted to the facility on 02/02/23. No Minimum Data Set (MDS) information was available for Resident #212. Review of Resident #212's complete medical record on 02/07/23, 02/08/23, and 02/09/23 revealed no advance directive information regarding code status. An interview with the Admission Coordinator was conducted on 02/09/23 at 10:30 AM who stated that she obtained advance directive information including code status information during the admission process. She stated that once the resident and/or family elected their code status they would indicate that on a form and she would sign as a witness. Once the form was completed and signed, she would give that form to the Medical Record Clerk to be uploaded into the medical record. The Admission Coordinator reviewed Resident #212's information in the medical record and was unable to locate the document. An interview with the Medical Record Clerk was conducted on 02/09/23 on 10:35 AM who	F 578	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ The Advanced Directive were clarified and corrected for residents #212 and #213 on 2/9/23 by the Social Worker. Orders were entered in the electronic records by the Unit Manager on 2/9/23. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ A 100% audit was completed by the social worker on current residents Advance Directive status. Any resident identified, status was verified, and an order was entered in the residents' electronic record by the unit manager. Audit was completed on 3/03/23. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 3/13/2023The Regional Nurse consultant educated the Unit Managers, the Director of Nursing, Social worker, and the admission coordinator on the process for completing the Advance directive upon admission. The admissions coordinator will verify upon admission and obtain signed paperwork regarding Advance Directive Status, give to the admissions nurse, the admissions nurse	

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F 578	Continued From page 10 confirmed that she uploaded the code status form that was signed during the admission process into the electronic medical record, but stated she and one other staff member were the only ones that had access to the document. The Medical Record Clerk was able to provide Resident #212's full code agreement on 02/09/23. The form was signed by the resident and the Admission Coordinator and was dated 02/02/23. An interview was conducted with Nurse #6 on 02/09/23 at 11:24 AM who confirmed that she had admitted Resident #212 to the facility on 02/02/23. She reviewed Resident #212's medical record and stated she could not find any advance directive information or code status information. She stated generally the resident's code status was on the discharge summary and the nursing staff would enter an order for it when the resident arrived. Nurse #6 stated that Nurse #4 generally entered the orders on new admissions, and she was not sure why there was not an order in Resident #212's medical record. Nurse #4 was interviewed on 02/09/23 at 11:31 AM who confirmed that she had entered orders for Resident #212 on admission. Nurse #4 reviewed the medical record and could not locate the advance directive or code status information. She stated "it must not have been on the discharge summary or I would have entered the order." An interview with the Regional Nurse Consultant was conducted on 02/10/23 at 11:20 AM who stated that advance directive information including code status information was obtained during the admission process. Once the	F 578	to obtain order and enter in the electronic record. The Director of Nursing and the Unit Managers will utilize the admissions check list to verify the Advance Directive Status has been completed upon admission. Social work to review Advance Directives during the 72-hour meeting. Education was completed by 3/6/23. The staff development coordinator educated the licensed nurses to verify Advance Directive Status upon admission. Ensure the order is entered in the electronic record. Education was complete by 3/6/23. Staff not educated will not be permitted to work until education is complete. New hires will be educated on the topic during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: As of 3/13/2023 The Social work will audit new admission for verification of Advanced Directive Status, verify the order has been entered into the residents electronic record. Audit will be conducted 5xper for 4 weeks; 3x per week for 4 weeks; and then1xper week for 4 weeks. The social worker will report the results of the audit to the monthly Quality Assurance and Performance Improvement committee x3 months or until substantial compliance is achieved and maintained.	

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Admission Coordinator obtained the form from the resident and/or family that information should be delivered to the admission nurse to ensure that there was an order entered into the medical record. Then the Social Worker (SW) would follow up at the seventy two hour meeting with any additional paperwork that needed to be completed.

The Administrator and Director of Nursing (DON) were interviewed on 02/10/23 at 2:28 PM. The Administrator stated that he learned on 02/09/23 that there were two new admissions that came in and their advance directives were not in their record. He added that they also learned the advance directive information should be completed before the seventy-two-hour meeting. The DON stated that it seemed like an oversight on their part and the staff should reaffirm the code status that was on the discharge summary upon admission to the facility.

2. Resident #213 was admitted to the facility on 02/02/23.

No Minimum Data Set (MDS) information was available for Resident #213.

Review of Resident #213's complete medical record on 02/07/23, 02/08/23, and 02/09/23 revealed no advance directive information regarding code status.

An interview with the Admission Coordinator was conducted on 02/09/23 at 10:30 AM who stated that she obtained advance directive information including code status information during the admission process. She stated that once the resident and/or family elected their code status

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they would indicate that on a form and she would sign as a witness. Once the form was completed and signed, she would give that form to the Medical Record Clerk to be uploaded into the medical record. The Admission Coordinator reviewed Resident #213's information in the medical record and was unable to locate the document.

An interview with the Medical Record Clerk was conducted on 02/09/23 on 10:35 AM who confirmed that she uploaded the code status form that was signed during the admission process into the electronic medical record, but stated she and one other staff member were the only ones that had access to the document.

The Medical Record Clerk was able to provide Resident #213's Do Not Resuscitate form on 02/09/23. The form was signed by the resident's family and was dated 02/02/23.

An interview was conducted with Nurse #6 on 02/09/23 at 11:24 AM who confirmed that she had admitted Resident #213 to the facility on 02/02/23. She reviewed Resident #213's medical record and stated she could not find any advance directive information or code status information. She stated generally the resident's code status was on the discharge summary and then nursing staff would enter an order for it when the resident arrived. Nurse #6 stated that Nurse #4 generally entered the orders on new admissions, and she was not sure why there was not an order in Resident #213's medical record.

Nurse #4 was interviewed on 02/09/23 at 11:31 AM who confirmed that she had entered orders for Resident #213 on admission. Nurse #4

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F 578	Continued From page 13 reviewed the medical record and could not locate the advance directive or code status information. She stated "it must not have been on the discharge summary or I would have entered the order." An interview with the Regional Nurse Consultant was conducted on 02/10/23 at 11:20 AM who stated that advance directive information including code status information was obtained during the admission process. Once the Admission Coordinator obtained the form from the resident and/or family that information should be delivered to the admission nurse to ensure that there was an order entered into the medical record. Then the Social Worker (SW) would follow up at the seventy-two-hour meeting with any additional paperwork that needed to be completed. The Administrator and Director of Nursing (DON) were interviewed on 02/10/23 at 2:28 PM. The Administrator stated that he learned on 02/09/23 that there were two new admissions that came in and their advance directives were not in their medical record. He added that they also learned the advance directive information should be completed before the seventy-two-hour meeting. The DON stated that it seemed like an oversight on their part and the staff should reaffirm the code status that was on the discharge summary upon admission to the facility.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		3/10/23

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but not limited to receiving treatment and supports for daily living safely.

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

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

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

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

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

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

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident,

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1. Address how corrective action will be

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and staff interviews the facility failed to maintain a clean homelike environment for residents by failing to maintain an odor free environment for 3 of 3 halls (North, South and West). The facility also failed to clean the floor of a resident's room, provide bed linens, and repair a toilet in a resident room. (South hall).

The findings included:

1. On 2/7/23 at 2:38 PM an observation was conducted. The toilet was heard running when entering Resident #61's room. Resident #61 was observed in his room sitting in his wheelchair, there was a strong odor of urine in Resident #61's room. A soiled brief was observed on his floor, and there were no linens on his bed. Resident 61's bathroom was observed, the water in the toilet was running continuously and there was a large amount of a brown substance that resembled feces on the bathroom floor.

During an interview on 2/7/23 at 2:42 PM Nurse Aide (NA) #6 entered Resident #61's room. NA #6 revealed Resident #61 often took off his brief, thew it on the floor, and would put his clothes back on. She stated he often refused care, and would have accidents in the floor so the room smelled bad. This would occur multiple times a day. NA #6 further stated they did not put linen on resident #61's bed because he would dirty them up and he sometimes put them on the floor. This surveyor brought the brown substance that resembled feces on the bathroom floor to NA #6's attention. She stated, "he does that all the time". NA #6 then picked up the soiled brief and placed it in a clear plastic bag to discard, then exited the room. The brown substance that resembled

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accomplished for those residents found to have been affected by the deficient practice:¿¿
As of 2/10/2023 resident #61 room has been cleaned and the bed made by nursing department staff. As of 2/10/2023 the Maintenance Director has repaired resident #61s toilet. As of 2/15/2023 all hallways have been cleaned by housekeeping to ensure hallways remain free of odors.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿
All residents have the potential to be affected by this deficient practice therefore, a 100% audit of all resident rooms and hallway have been checked by the Maintenance Director and Housekeeping Department to ensure rooms and hallways are clean, odor free, toilets working properly, and beds made as of 3/06/2023.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
As of 3/6/2023 all nursing, housekeeping and Maintenance staff have been re-educated on providing residents with a safe, clean, functioning room and common areas by Administrator/Director of Nursing/Housekeeping Supervisor. Education included beds made, rooms and floors clean, odor free environment and properly functioning toilets. As of

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feces was left on his bathroom floor.

A continuous observation was made of the hall where Resident #61 resided on 2/7/23 from 2:45 PM until 3:20 PM. At 2:48 PM NA #6 entered Resident #61's room, asked if he needed anything then exited the room. At 3:13 PM NA #6 entered Resident #61's room. She exited the room spraying air freshener and a clear plastic bag that she carried to the soiled utility. There was a cart stocked with bed linen and towels on the hall where resident #61 resided. At 3:20 PM Resident #61's bathroom was observed, the brown substance that resembled feces had been removed.

During an interview on 2/7/23 at 3:23 PM NA #6 revealed Resident #61's room was difficult to keep clean. She stated housekeeping and nursing were responsible for keeping resident rooms clean. NA #6 further stated she had cleaned Resident #61's bathroom floor but she should have done it right away. She got busy with another resident. She stated she would put linen on Resident #61's bed.

An observation on 2/8/23 at 11:56 AM revealed the toilet was heard running from outside Resident #61's room door. Resident #61 was in his room, there was no linen on his bed. Resident # 61 asked this surveyor to leave the room. His bathroom was not observed.

An observation on 2/8/23 at 12:00 PM revealed there was a cart stocked with bed linen and towels on the hall where resident #61 resided.

On 2/9/23 at 11:10 AM an observation and interview were conducted. Housekeeping was

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3/6/2023 Director of Nursing re-educated all Nursing staff on removing all trash after providing care and making beds during rounds. Housekeeping Supervisor will monitor 4 rooms daily/ 5 days week for 12 weeks to ensure resident rooms and hallways are clean and odor free.

Maintenance will monitor 5 resident rooms daily Monday through Friday for 8 weeks then 5 resident room toilets weekly for four weeks to ensure toilets are functioning properly.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Housekeeping Supervisor and Maintenance Director will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan.

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F 584	Continued From page 17 observed exiting Resident #61's room. Housekeeper #2 revealed she cleaned resident rooms at least once daily. She would return to a residents room if staff requested. When cleaning she wiped the walls, doors, bedframe, nightstand, and window sills. She also cleaned the bathrooms, changed the trash, and mopped the floors. She stated Resident #61's room was hard to clean, there was always urine and feces on the floor in his room. She explained the housekeepers shifts ended at 2 PM and 3PM. Daily when she returned to clean his room, his floor would have urine and feces on it, and the feces was often dried. She stated Resident #61's toilet was always running, and she had reported this to nursing and maintenance. Resident #61's room was observed clean. There were no linens on his bed. During an interview on 2/9/23 at 11:21 AM Nurse #2 revealed Resident #61's room was often messy, and at times there would be feces and urine on his floor. He stated when he saw these issues, he would let housekeeping know or delegate to the nurse aide. If housekeeping and the nurse aide were busy, he would clean it himself. Nurse #2 revealed residents' beds should be made daily and the linen should be changed if soiled. He further revealed he did not notice Resident #61's toilet running. During an interview on 2/10/23 at 8:19 AM the Director of Maintenance revealed if something needed repaired staff communicated it to him by verbally telling him, or by writing it in the maintenance logbook. The Maintenance Director further revealed he was notified that Resident #61's toilet was running on the day prior. He stated it needed a new fill valve and he did not	F 584		

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have it yet.

An interview with the Director of Nursing and the Corporate Nurse Consultant on 2/10/23 at 5:25 PM revealed residents linen should be changed with baths and if soiled. The Nurse Consultant stated if a resident had urine or feces on their floor, nursing should clean it immediately. Nursing should not wait for housekeeping to clean up resident accidents, and housekeeping should mop after the initial clean up. They stated any issues with equipment should be reported to maintenance.

2. A continuous observation occurred on 2/7/23 from 12:30 PM until 1:30 PM with a strong odor of urine noted from the carpet in the sitting areas on the North and West units.

A Resident Council Meeting was held on 2/8/23 at 3:30 PM with 9 residents who regularly attended Resident Council meetings. During the meeting, all 9 of the residents in attendance stated that they recently noticed odors of urine and feces coming from resident rooms into the hallways and lingered for 30 minutes or more.

Nurse #1 stated in an interview on 2/9/23 at 3:57 PM that for the past 9 months he noticed lingering odors on the North and West units which were more prevalent lately. Nurse #1 stated these odors lingered for 30-45 minutes resolved with time and deodorizers. Nurse #1 stated a resident on the West unit was identified and described as non-compliant with nursing care, had recently experienced more frequent incontinence

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F 584	Continued From page 19 episodes. He stated odors were common during incontinence care, but when multiple residents received incontinence care at the same time combined with residents who were non-compliant with nursing care, the odors were stronger and difficult to resolve. Nurse #1 stated housekeeping staff used EPA approved disinfectant and deodorizer that helped but did not always resolve the odors. A continuous observation occurred on 2/10/23 from 12:41 PM until 1:00 PM with a strong odor of urine noted from the carpet in the sitting areas on the South and West units. Housekeeper #1 was interviewed on 2/10/23 at 3:12 PM. He stated that he used an EPA approved disinfectant and deodorizer when he cleaned resident rooms as soon after nursing care as he could to reduce odors in the hallways, but because of some strong body odors and strong urine odors it was difficult to resolve odors. Housekeeper #1 stated that urine spilled onto the floor in resident bathrooms and the carpet in commons areas also had strong urine odors and that cleaning/disinfecting did not correct the problem. He stated that he had communicated this concern to his previous and current manager. The Housekeeping Director was interviewed on 2/10/23 at 12:41 PM to 1:00 PM during a continuous observation of the South and West units. During the observation and interview, the Housekeeping Director stated he did not notice an odor of urine or feces on the South unit, but he did identify a strong urine odor on the West unit during the observation. He stated he was not aware of a resident concern related to odors. He stated that he rounded 2 - 3 times daily, Monday -	F 584		

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F 584	Continued From page 20 Friday and had not noticed a concern with odors but stated that being in the same environment every day and wearing a surgical mask could contribute to why he did not identify any odors. He stated that the staff in the housekeeping department had an EPA approved deodorizer that was used as needed to control odors. He stated that for lingering odors he would have to determine if the source of the odor may have been the carpet or the furniture. During a follow up interview, on 2/10/23 at 1:41 PM, the Housekeeping Director stated that he was just informed that a resident had previously urinated on the carpet in the sitting area on the West unit which was the cause of the current strong urine odor. The Administrator was interviewed on 2/10/23 at 11:30 AM and stated that he was aware of the resident complaints of strong urine odors on West unit and asked the Housekeeping Director to monitor for this while rounding. The Administrator stated that there was a resident on the West unit who refused nursing care and that staff tried to manage the odors from this resident's room. A follow up interview with the Administrator on 2/10/23 at 12:50 PM revealed he identified a current strong urine odor on the West unit and that he would develop a plan with the Housekeeping Director to address it.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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	F 602		3/10/23

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F 602	Continued From page 21 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews and Pharmacist Consultant interview the facility failed to prevent drug diversion on 2 occasions for 1 of 3 residents reviewed for misappropriation of resident property (Resident #80). The findings included: Resident # 80 was admitted to the facility on 7/13/22 with diagnoses that included amyotrophic lateral sclerosis (ALS) (a nervous system disease that weakens the muscles), muscle weakness, respiratory failure, pain, and cognitive communication deficit. A significant change Minimum Data Set for Resident #80 dated 1/25/23 revealed she was cognitively intact with no rejection of care. Resident #80 was on a scheduled pain medication regimen and had as needed pain medications. The Plan of Care for Resident #80 updated on 10/14/22 revealed she was at risk for experiencing pain/discomfort related to being bedbound, quadriplegia, and ALS. The interventions included assess the resident's pain daily using a 1-10 scale and administer pain medications as needed. Assess need for additional medications for breakthrough pain. Monitor for worsening pain symptoms and notify physician of changes. Encourage the resident to take medication therapy for pain when needed	F 602	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Resident #80 regarding the incident related to missing liquid oxycodone on 12/22/22 was reported to DHHS, ASP, Law enforcement, DEA, NCBON, and Pharmacy. Residents were provided pain medication of oxycodone 10mg tabs via feeding tube. Resident did not c/o pain. Nurse #3 was suspended pending an investigation. An investigation was initiated. Licensed nursing staff were re-educated on the facility's polices on receiving and maintaining controlled medications in the facility. Educated was provided by the Staff development coordinator. Incident regarding resident #80 missing 20 tabs of 10mg of oxycodone on 1/9/23. The incident was reported to DHHS, APS, Law enforcement, Pharmacy, DEA and NCBON. Nurse #3 was suspended pending investigation. All nurses assigned to the medication cart where the residents� medications are stored completed a drug screening. The pharmacy completed a 100% audit on the controlled medications and provided education on the process for maintaining control substances in the facility for the Director of Nursing and the Staff Development Coordinator. The Staff	

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F 602	Continued From page 22 and as scheduled. Use non-pharmacological interventions for pain relief (position change, diversional activities, warm blankets). Review of Physician orders for Resident #80 revealed: Oxycodone hydrochloride (HCL) 5 milligrams (mg)/5 milliliters (ml) solution give 15 ml (15 mg) via Gastric Tube(g-tube) (a tube inserted directly into the stomach for feeding and medications) twice a day for pain 10/6/22-12/14/22. Oxycodone HCL 5 mg/5 ml solution-give 7.5 ml (7.5 mg) via g-tube every 4 hours as needed, all doses must be 4 hours apart 11/21/22-12/14/22. Oxycodone HCL 5 mg/5 ml solution-give 7.5 ml (7.5 mg) via g-tube every 4 hours as needed 12/22/22-12/31/22. Oxycodone HCL 5 mg/5 ml solution-give 15 ml (15 mg) via g-tube twice daily for pain 12/22/22-12/31/22. Oxycodone HCL 5 mg/5 ml solution-give 10 ml (10 mg) via g-tube every 4 hours as needed 12/25/22-12/27/22. Oxycodone HCL immediate release (IR) 10 mg tablet give 10 mg via g-tube every 6 hours at 2 AM, 8 AM, 2 PM, and 8 PM 12/31/22-1/3/23. Pain assessment every shift document using 0-10 PAIN SCALE 0 = NO PAIN 1-3 = MILD PAIN 4-7 = MODERATE PAIN 8-10 = SEVERE PAIN 1/7/23. Oxycodone HCL 5 mg/5 ml solution give 5 ml (5	F 602	development coordinated re-education to the licensed nurses that the Admissions nurse and the Director of Nursing will remove discharged resident narcotics medication or discontinued meds from the medication carts and return to pharmacy. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ Pharmacy completed a 100% audit on all controlled substances dispensed from 7/1/22 through 1/10/23. Reviewed all the count sheets for these medications and tracked the disposition of unused medications. Audit was conducted on 1/19/23. Areas of concern identified were discussed with the Director of Nursing. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing was re-educated as of 3/13/2023 by the regional nurse consultant in maintaining controlled medication records in the facility in a file cabinet in his office. The admissions nurse and the Director of nursing will be the only 2 nurses to return control substances medications to the pharmacy. The floor nurses on the medication carts will be responsible for all other medication returns. The Nurse managers will report during morning meeting any residents discharges or any discontinued narcotic control medications. The Admissions	

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mg) via g-tube every 4 hours as needed for pain or discomfort 1/7/23-1/17/23.

Oxycodone HCL 5 mg/5 ml solution- one time dose Oxycodone 7.5 ml at 5 PM for pain 01/10/23.

Oxycodone HCL immediate release (IR) 15 mg tablet give twice daily - crush medication and administer via g-tube 1/10/23.

Oxycodone HCL (IR) 5 mg tab give 7.5 mg (1 and 1/2 TABLETS) every 4 hours as needed for pain - crush medication and administer via g-tube 1/16/23.

During an interview on 2/7/23 at 4:11 PM Resident #80 revealed after returning to the facility from a hospitalization she was missing oxycodone. She stated she did not know what happened to the medication. She further stated she used to take oxycodone liquid, but now she takes pills.

Review of a discharge summary for Resident #80 dated 12/22/22 revealed Resident #80 was admitted to the hospital on 12/14/22 and discharged on 12/22/22.

Review of Resident #80's oxycodone count sheet revealed when the resident went to the hospital on 12/14/22 the amount of oxycodone left on the cart was 414.5 ml and when the resident returned to the facility on 12/22/22 there was 360 ml of oxycodone on the cart. Resident #80's oxycodone count sheet also revealed the following:

On 12/14/22 there was 414.5 ml left of Resident

F 602

nurse and the Director of Nursing will remove the discharged resident narcotic medication or discontinued meds from the medication carts and return to pharmacy. Education was completed by 3/6/23. The Staff development coordinator re-educated the licensed nurses on the facility policies regarding receiving, storage, maintaining, and returning medications to pharmacy. Included in the education was the process for shift-to-shift count and signing at the start and then at the end of your shift that the count is correct and verifying medications on hand. Education was completed by 3/6/23. Staff will not be permitted to work until education is complete. Any new staff hired will be educated during orientation.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Nursing and/or Nurse management will audit medication carts 6 x per week for 4 weeks; 3xper week for 4 weeks; then 1x weekly for 4 weeks to verify that the narcotic count is correct on each medication cart, the shift-to-shift count sheet is signed at the change of each shift, and that discontinued/ or discharged Narcotic medications are returned to pharmacy when discontinued. The results of the audit will be reported by the Director of Nursing to the Quality Assurance and Performance Improvement Committee monthly x3 months or until substantial compliance is achieved and maintained.

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#80's oxycodone

On 12/17/22 a count was done of the resident's oxycodone and there was 402.5 ml remaining

On 12/20/22 a count was done of the resident's oxycodone and there was 400 ml remaining

The next row had 12/2 in the date column, 15 ml in the given column, the remainder column was illegible and was signed by Nurse #3. The row was struck threw with a straight line.

The next row was illegible and signed by Nurse #3.

The next row had an illegible date and amount given and was signed by Nurse #3 and the number 385 circled at the end of the row.

The next row was dated 12/22/22 at 7:00 PM with a note that read corrected liquid count 360 ml signed by Nurse #3 and cosigned by another nurse.

Review of the December 2022 Medication Administration Record for Resident #80 revealed there was no oxycodone administration documented on 12/22/22 by Nurse #3.

During an interview with the Wound Nurse on 2/9/23 at 4:41 PM revealed she was also the evening nurse supervisor and on 12/22/22 she was notified by the oncoming nurse that was going to care for Resident #80 that the resident's oxycodone count was off, and she would not accept keys from Nurse #3 until the discrepancy was resolved. Resident #80 had returned to the facility from the hospital on that day. The Wound

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F 602	Continued From page 25 Nurse indicated that Nurse #3 appeared sleepy, and it took her a long time to correct the medication count. Earlier in her shift she observed Nurse #3 sleeping on her cart. She further indicated the final count was 360 ml, approximately 40 ml less than expected. She reported this to the Director of Nursing (DON). An interview was conducted with Nurse #3 on 2/10/23 at 1:25 PM. She revealed the count was off on 12/22/22, but she corrected the count with the oncoming nurse. She further stated the facility conducted an investigation and concluded the oxycodone was subtracted wrong. She stated the bottles were hard to read. She further revealed she did not recall creating any illegible documentation on the oxycodone count sheet. An interview with the DON on 2/10/23 at 3:32 PM revealed he was notified of the discrepancy by the Wound Nurse on 12/22/22. He was also made aware that Nurse #3 was observed dozing off and sleepy on that shift. An investigation was completed. During the investigation no staff members were drug screened. He further revealed the facility had never had any concerns with Nurse #3. The DON stated Nurse #3 told him her sleepiness was the result of family issues at home, therefor the facility did not think a drug screen was necessary. He revealed he consulted with corporate on this situation and they were in agreement. The discrepancy was thought to be a miss count because the oxycodone bottles were difficult to read. He further revealed there were also concerns voiced about if the liquid oxycodone had been tampered with or switched out for another liquid medication. A new bottle of oxycodone was ordered for Resident #80. The bottle of oxycodone in	F 602		

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F 602	Continued From page 26 question was sent back to the pharmacy to be evaluated. The DON stated the pharmacy verified the medication was oxycodone. Review of a report from Consultant Pharmacist #1 dated 12/29/22 read in part: Multiple pharmacist had analyzed the returned bottle of medication as compared with the stock bottle of oxycodone in the pharmacy. We cannot detect a significant difference between the 2. It must be noted that oxycodone and robitussin are very similar in appearance, viscosity, and smell. Because of these similarities, the extent of any tampering with and between either of these medications, if it is occurring, can only be identified by analysis in a laboratory. If there are concerns of potential tampering with the oxycodone solution, additional security measures over and above the normal should be taken to safeguard the medication. Oxycodone tablets can be administered crushed via tube. Oxycodone tablets will be easier to track and offer a viable alternative to the oxycodone solution. During an interview on 2/10/23 at 3:35 PM the Administrator revealed when he found out about the discrepancy with Resident #80's oxycodone the facility started an investigation and Nurse #3 was suspended until the investigation was completed. The Administrator explained after the investigation education was provided to staff. The facility also began a process to send controlled medications back to the pharmacy if a resident was discharged, in the hospital or the medication had been discontinued. This task was completed by the DON, supervisor, or designated staff.	F 602		

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A nurse note dated 12/30/22 read in part, in the presence of the Nurse Practitioner, sitter, this nurse, and the Administrator, informed resident that due to concerns of not receiving the correct amount of her liquid pain medication she will no longer be getting it via liquid but by pill form. It will be crushed to ensure she is getting the correct amount.

Review of Resident #80's medical record revealed she was sent to the hospital on 1/3/22.

An interview was conducted with Nurse #4 on 2/9/23 at 5:15 PM revealed Nurse #4 was assigned the task of checking the carts and sending discontinued medications and medications for residents that were not in the facility back to the pharmacy. Nurse #4 stated she checked the carts daily. On 1/4/23 when Resident #80 was in the hospital she was checking the cart. Resident #80 had a card of oxycodone tablets and some oxycodone liquid on the cart. Nurse #4 further stated she was going to collect a Resident 80's medications, but Nurse #3 was there and asked Nurse #4 to leave the oxycodone tablets because she thought the resident was returning to the facility on that day. Nurse #4 explained she left the oxycodone on the cart and Nurse #3 was to give them to her if the resident did not return. Nurse #4 revealed a few days later she was approached by Nurse #5 regarding the oxycodone pills. She was asked why she sent the oxycodone tablets back to the pharmacy. Nurse #4 revealed the last she had seen the pills was when she left them on the cart at Nurse #3's request. Nurse #3 did not return the oxycodone tablets to her.

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Review of a controlled medication count sheet for Resident #80's oxycodone liquid revealed the medication was sent back to the pharmacy by Nurse # 4 and cosigned by Nurse #3 on 1/4/22.

During an interview 2/9/23 at 3:54 PM Nurse #5 revealed when she came in for her shift on 1/6/23 Resident #80 had returned to the facility. During shift report she was told by Nurse #3 that Resident #80 was back from the hospital and she was in need of pain medication. Nurse #3 explained to that Resident #80's oxycodone tablets had been sent back to the pharmacy while she was in the hospital by Nurse #4. Nurse #3 obtained an order for oxycodone liquid before she left shift. Nurse #5 stated when she saw Nurse #4 on the morning of 1/9/22 she asked her about the oxycodone tablets that were sent back to the pharmacy. She was told by Nurse #4 the medications were not returned and they should've still been on the cart. Nurse #5 explained on that morning of 1/9/23 Nurse #3 was her relief. Nurse #3 questioned her about what she told the administrator and Nurse #4 about the oxycodone tablets. Nurse #5 stated that Nurse #3 told her she never said the oxycodone tablets were sent back and that she meant the oxycodone liquid was sent back. Nurse #5 stated that was not true, they did not count any oxycodone tablets on 1/6/23 because there were none on the cart. She further stated after their conversation her and Nurse #3 counted the cart, the count was correct, and they signed the sheets for that morning. Shortly after, the Administrator came to her looking for the Narcotic log and some of the count sheets were missing from the book.

During an interview on 2/10/23 at 1:25 PM Nurse

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#3 revealed on 1/9/23 she was asked by the administrator had she seen the oxycodone tablets for Resident #80. She told the Administrator on the last shift she worked, 1/6/23, the oxycodone pills were on the cart. She stated she remembered Resident #80 came back to the facility with a new order for liquid oxycodone instead of the tablets, therefor she had to request the liquid from the pharmacy. The pills remained on the cart and were counted with Nurse #5. She further stated she did not tell Nurse #5 the oxycodone tablets were sent back to the pharmacy because they were on the cart, and she did not remove the count sheet for Resident #80's oxycodone tablets.

Review of a discharge summary for Resident #80 dated 1/6/23 revealed Resident #80 was admitted to the hospital on 1/3/23 and discharged on 1/6/23. On the discharge summary the section titled Discharge medications read in part: continue Oxycodone 10 mg tablet, 10mg via g-tube every 6 hours at 2 AM, 8 AM, 2 PM and 8 PM. There were no new or stop orders on the discharge summary.

During an interview on 2/9/23 at 4:41 PM the Wound Nurse revealed on the night of 1/9/23 she was going to provide wound care for Resident #80. Resident #80 requested pain medication, so the Wound Nurse asked Nurse #3 who was caring for Resident #80 at that time to give her something for pain. Nurse #3 brought in the medication in a water cup, and there was a question if the medication was Oxycodone. Nurse #3 told the resident and Wound Nurse the medication came from the oxycodone bottle. The resident declined the medication, and an order

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was obtained for an oxycodone tablet. The tablet was pulled from the medication dispensing machine and administered to Resident #80. The Wound Nurse reported the events to the DON who requested she notify law enforcement. The Wound Nurse stated she called the police, but Nurse #3 did not wait for them to arrive, she stated she needed to go home. When the police arrived, they took statements and looked at the medication. The Wound Nurse stated the police officers did not believe the medication was oxycodone, but they did not take it from the facility because they did not have a way to secure the medication. The medication was placed back on the cart.

During an interview on 2/10/23 at 3:35 PM the Administrator revealed around 1/9/23 he learned about the missing oxycodone tablets for Resident #80 and began speaking to staff about the incident and taking statements, during this same time period he learned about the incident regarding Resident #80's oxycodone liquid being questionable. He explained there were approximately 20 oxycodone tablets unaccounted for and the count sheet for those tablets was also missing. He revealed the facility had a process in place since December 2022 to collect and return medications to the pharmacy if they were discontinued or if the resident was out of the facility. It was reported to him that Nurse #4 attempted to collect the oxycodone tablets and liquid that were left on the cart while she was in the hospital. When Nurse #4 was trying to collect the oxycodone, Nurse #3 asked Nurse #4 to leave the oxycodone tablets and send back the liquid because the resident may return and would need pain medication. Nurse #4 only sent back the oxycodone liquid. The Administrator

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F 602	Continued From page 31 explained on 1/9/23 the facility requested an in-house drug screens for all staff that worked the cart where Resident #80's medications were kept within that prior week. He stated all staff drug screens were good except Nurse #3's that had an issue with the temperature. They collected the drug screen twice in house for Nurse #3 and the temp was 90 degrees. The administrator revealed that on the morning of 1/10/23 he learned of an issue regarding Resident #80's liquid oxycodone and there was a question if the medication that was prepared for Resident #80 was oxycodone. He stated when he spoke to the resident that morning she wanted and was willing to take the medication, so it was not sent back to the pharmacy based on information from the resident. The administrator revealed Nurse #3 was suspended pending their investigation and had not returned to work for the facility. Since the missing oxycodone tablets the facility had not had any issues with controlled medication counts. Review of a report from Consultant Pharmacist #2 date 1/19/23 revealed Consultant Pharmacist #2 ran a report of every controlled substance dispensed from the pharmacy from 7/1/22 through 1/10/23. She reviewed all the count sheets for these medications and tracked the disposition of unused medications. The report further indicated there were some medications with no count sheet. It was noted that the facility had "poor" documentation on the count sheets. This had occurred repeatedly with one nurse. The Report also read in part: It is impossible to truly know if items were diverted, because there was not a good filing system for these documents. However, In the eyes of an auditor, this would be considered diversion because you can not show any proof of what was done with the	F 602		

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F 602	Continued From page 32 controlled prescriptions. During an interview on 2/10/23 at 6:18 PM the Consultant Pharmacist #2 stated she completed a controlled medication audit of the past 6 months for the facility on all controlled medications. She stated she found documentation that was inconsistent, missing dates and missing cosigns for medication wasting. Nurse #3's documentation was the most inconsistent. She stated the facility's paperwork for controlled substance counts were not in order.	F 602		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to submit an update or make	F 644	1.Address how corrective action will be accomplished for those residents found to	3/10/23

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F 644	Continued From page 33 recommendations for Level II Preadmission Screening and Resident Review (PASRR) for 2 of 4 sampled residents (Resident #104 and Resident #42). The findings included: 1.Resident #42 was admitted to the facility on 3/11/21 with diagnoses inclusive of schizoaffective disorder, bipolar disorder, and schizophrenia. A review of a Halted PASRR Level II Determination Notification (halted due to dementia primary, terminal prognosis, or does not meet Level II Target Population Criteria) dated 3/22/21 indicated Resident #42 did not meet the federal definition of mental illness at the time the PASRR was processed, implying either that there was no evidence of mental illness or there was a primary diagnosis of dementia. It also indicated no further Level I screening was required unless a significant change occurred with the individual's mental status which suggested a psychiatric disorder that was not dementia. A quarterly Minimum Data Set (MDS) assessment dated 12/16/22 indicated Resident #42 had moderate cognitive impairment. A review of Section A 1500 PASRR of the MDS (dated 6/14/22, 9/20/22, and 12/16/22) further indicated Resident #42's PASRR was coded as the Resident was not evaluated by Level II PASRR to determine the presence of a serious mental illness or related condition. A review of a psychiatry progress note dated 1/4/23 indicated Resident #42's medications (for schizoaffective disorder, anxiety, and insomnia)	F 644	have been affected by the deficient practice:¿ Residents #104 and #42 Level II PASARR have been completed by Social Worker as of 3/01/2023. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ All residents have the potential to be affected by the same deficient practice of Level II PASSR screening. All current residents had records reviewed and PASARR screen completed, if needed by Social Worker as of 3/10/2023. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 3/10/2023 Administrator has re-educated facility Social Workers on the facility policy for PASARR. As of 3/10/2023 Social Worker will review all new admissions for need of PASARR screening upon admission and following any change in diagnoses inclusive of schizoaffective disorder, bipolar disorder, and schizophrenia. This task will be completed daily for 5 days for 12 weeks. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Social Worker is responsible for implementing this plan of correction for new admission or those following a change in condition and reporting the observed findings from the audit to the	

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F 644	Continued From page 34 were managed and there was one recent isolated behavior incident that involved the Resident becoming territorial with another resident and no physical altercation was reported. No medication changes were recommended. A progress note dated 1/23/23 indicated Mental Health Nurse Practitioner (NP) was notified of Resident #42's recent change in behavior that involved striking another resident. The note further revealed a new order for Ativan medication twice a day as needed for 7 days due to agitation and one-on-one supervision was initiated. A review of a psychiatry progress note dated 1/26/23 indicated staff reports of agitation with combative behaviors. Ativan was prescribed as needed for behaviors audio/ visual hallucinations or worsening symptoms of depression and no reports of manic behaviors. Sertraline medication for anxiety and Trazadone was prescribed for sleep support. Resident #42 was tolerating medications well. A revised Care Plan dated 1/26/23 revealed Resident #42 had episodes of combative behaviors. Interventions included a psychiatric consult, administer psychotropic medications as ordered, inform resident that hitting/ kicking other was not acceptable, involve family, when possible, remove from situations that may increase the agitation. An interview with the Director of Nursing and the Regional Nurse Consultant on 2/10/23 at 2:54 PM indicated it was their expectation that a recommendation update should have been submitted for the Halted PASRR Level II when a	F 644	Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but is not limited to, the Director of Nursing, Administrator, MDS Coordinator, Assistant Director of Nursing, Social Worker, Activities Director, Dietary Manager, Maintenance Director, Medical Records, and Medical Director. The audits will be reviewed monthly and recommendations to change the plan of correction will occur if the facility does not maintain compliance with this regulatory requirement. The plan of correction has the opportunity to be changed to include additional education and/or monitoring to sustain compliance.	

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significant change (increased combative behaviors) was identified and documented in the medical record.

An interview the Regional MDS Consultant on 2/10/23 at 11:10 AM revealed there had been staff changes in Social Work and MDS who were responsible for entering significant changes which would have triggered a PASRR update for Resident #42. She further revealed the Resident should have been referred for a PASRR renewal.

An interview with the Administrator on 2/9/23 at 3:35 PM indicated he was recently made aware that an update was not submitted to the Level II PASRR since Resident #42's behaviors began. He further indicated it was his expectation that the Halted Level II PASRR should have been updated for the Resident.
2. Review of a PASRR (Preadmission Screening and Annual Resident Review) Level I Determination Notification, dated 7/26/22 recorded Resident #104 had been screened for services and determined he did not meet the federal definition for mental illness. It also recorded that the Level I screen would remain valid unless a significant change occurred which suggested a diagnosis of mental illness or mental retardation or if the diagnosis was present and required a change in treatment needs.

Resident #104 was admitted to the facility 8/5/22 and re-admitted to the facility on 2/6/23 from the hospital. The diagnoses of bipolar disorder was added to his medical record on 8/8/22 and conduct disorder was added to his medical record on 8/11/22.

An admission Minimum Data Set (MDS)

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assessment dated 8/12/22, noted that Resident #104 was not currently considered by the state Level II PASRR process to have serious mental illness. Rejection of care was noted as demonstrated 4-6 days during the 7 day assessment period.

A quarterly MDS assessment dated 12/7/22 noted Resident #104 had demonstrated rejection of care 4-6 days during the 7 day assessment period.

A care plan, dated 8/16/22, revised 11/14/22, 12/14/22, 1/1/23, 1/3/23, 2/1/23 and 2/7/23 for behaviors recorded Resident #104 rejected care demonstrated when he refused medications, refused meals, psych treatment/evaluation, Nurse Practitioner services, Director of Nursing services, transportation to appointments, and he demonstrated verbal/physical aggression towards staff talking loudly with the use of foul language, pushed a staff member, pushed down a medication cart, and exhibited signs/symptoms of paranoia when he alleged food provided was unsafe to eat.

During an interview on 2/09/23 at 4:36 PM, Social Worker (SW) #1 stated she completed the admission and quarterly MDS assessments. SW #1 stated that Resident #104 was discharged to the hospital for further evaluation on 2/1/23 after he pushed a staff member. SW #1 stated that it was her intention to complete the PASRR Level II referral when he re-admitted to the facility on 2/6/23, but now she realized the referral should have been made when she completed the 8/12/22 admission MDS.

The Regional MDS Consultant was interviewed

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F 644	Continued From page 37 on 2/10/23 at 11:06 AM and stated that Resident #104 was diagnosed with bipolar disorder prior to admission to the facility and a Level II PASRR determination should have been made prior to admission. She further stated when Resident #104's behaviors increased, staff should have made a Level II PASRR referral. The Administrator stated in an interview on 2/10/23 at 11:40 AM, that once staff determined that Resident #104 had behaviors that increased while he was a resident in the facility, staff should have worked to obtain the necessary PASRR screen.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		3/10/23

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F 655	Continued From page 38 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a baseline care plan within forty-eight hours of admission for a resident that had a urinary catheter (Resident #212) and for a resident that was an elopement risk and had an elopement device in place (Resident #213) for 2 of 2 new admissions reviewed. The findings included: 1. Resident #212 was admitted to the facility on 02/02/23 with benign prostatic hypertrophy. Review of an admission note dated 02/02/23 indicated that Resident #212 had a urinary catheter on admission that was draining clear	F 655	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ Residents #212 and #213 baseline care plans were completed and reviewed during the 72-hour meeting with the resident/responsible party on 2/9/23 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ A 100% audit was completed by the Minimal Data Set Coordinator to verify the baseline care plan was completed within 48 hours for all new admissions within the last 30 days. The audit was	

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yellow urine. The note was electronically signed by Nurse #6.

No Minimum Data Set (MDS) information was available for Resident #212.

Review of Resident #212's medical record on 02/07/23, 02/08/23, and 02/09/23 revealed no baseline care plan information.

MDS Coordinator #1 was interviewed on 02/09/23 at 12:13 PM who stated that the admission nurse was responsible for completing the baseline care plan. She stated that it was a paper form that they filled out and put on the residents medical record. MDS Coordinator #1 reviewed Resident #212's medical record and confirmed that there was no baseline care plan available. She stated that she had seen the baseline care plan for Resident #212, and she would go and look for it.

A follow up interview was conducted with MDS Coordinator #1 on 02/09/23 at 12:27 PM. She stated that the baseline care plan was completed on 02/09/23 and she could not answer why it was not completed within forty eight hours of Resident #212's admission. She added that once the baseline care plan was completed, they gathered and updated it at the seventy-two-hour meeting with the resident and then it would be used to develop the comprehensive care plan.

Review of the baseline care plan provided by MDS Coordinator #1 on 02/09/23 revealed that Resident #212 was admitted on 02/02/23 and was incontinent of bowel and bladder and did not indicate that Resident #212 had a urinary catheter.

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completed by 3/6/23. No other baseline care plans were incomplete.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Staff development coordinator educated the licensed nurse that a baseline care plan must be initiated upon admission. Education was completed by 3/6/23. The Regional Nurse consultant educated the Director of Nursing and the unit manager to verify during morning meeting that the baseline care plan has been initiated. Social work to set up a 72-hour meeting with the resident/responsible party to review care plan. Education was completed by 3/6/23. Staff will not be permitted to work until education is complete. New hires will be educated on the topic during orientation.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Unit managers will audit admission during clinical meeting to verify the completion of the baseline care plan 5xper week for 4 weeks; 3xper for 4weeks; then 3xper week for 4 weeks. The results of the audit will be reported by the Director of nursing to the Quality Assurance and Performance Improvement Committee monthly x3 months or until substantial compliance is achieved and maintained.

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F 655	Continued From page 40 Nurse #6 was interviewed on 02/09/23 at 12:15 PM and confirmed that she admitted Resident #212 to the facility on 02/02/23. She stated she did not complete any baseline care plan as she did not know she was supposed to complete one. Nurse #6 stated that she believed someone else took care of the resident's care plan. Nurse #6 confirmed that Resident #212 was admitted to the facility with urinary catheter. The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM who explained he was still very new to the DON position and was still learning. The DON stated that they talked about each new admission and the completion of the baseline care plan in the daily clinical meeting. The DON stated from his understanding it was just overlooked. 2. Resident #213 was admitted to the facility on 02/02/23. Review of a nurses note dated 02/02/23 read in part, resident is alert with confusion and refused skin checks. Resident paces up and down hall, reoriented to room multiple time by staff. Resident is ambulatory with some unsteadiness. Review of nurses note dated 02/03/23 read in part, Resident is very confused, continue pacing in the unit and other floors in resident room. He refuses to be redirected. There is no Minimum Data Set (MDS) information available for Resident #213. Review of Resident #213's medical record on 02/07/23, 02/08/23, and 02/09/23 revealed no baseline care plan information.	F 655		

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MDS Coordinator #1 was interviewed on 02/09/23 at 12:13 PM who stated that the admission nurse was responsible for completing the baseline care plan. She stated that it was a paper form that they filled out and put on the resident's medical record. MDS Coordinator #1 reviewed Resident #213's medical record and confirmed that there was no baseline care plan available. She stated that she had not seen the baseline care plan for Resident #213, but she would go and look for it.

Social Worker #2 was interviewed on 02/09/23 at 4:13 PM who confirmed that she had just completed the baseline care plan for Resident #213 on 02/09/23. She stated that generally she completed the baseline care plan during the seventy two hour meeting but could not say why this baseline care plan was not completed. Social Worker #2 stated that she did not recall having a seventy two hour meeting with Resident #213 or his family and maybe that was how it got overlooked.

The baseline care plan was obtained from Social Worker #2 on 02/09/23 and indicated that Resident #213 admitted to the facility on 02/02/23 and the care plan was completed on 02/09/23. The care plan indicated that Resident #213 required an elopement device for his wandering.

Nurse #6 was interviewed on 02/09/23 at 12:15 PM and confirmed that she admitted Resident #213 to the facility on 02/02/23. She stated she did not complete any baseline care plan as she did not know she was supposed to complete one. Nurse #6 stated that she believed someone else took care of the resident's care plan.

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F 655	Continued From page 42 The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM who explained he was still very new to the DON position and was still learning. The DON stated that they talked about each new admission and the completion of the baseline care plan in the daily clinical meeting. The DON stated from his understanding it was just overlooked.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide nail care for 1 of 1 resident who was dependent on staff assistance for activities of daily living (Resident #81). The findings included: Resident #81 was admitted to the facility on 7/13/22 with diagnoses that included stroke, hemiplegia and hemiparesis of the right side, and depression. A quarterly Minimum Data Set for Resident #81 dated 10/17/22 revealed the resident was cognitively impaired with no refusals or rejection of care. He was totally dependent on staff for bathing and personal hygiene. The care plan for Resident #81 updated on 1/26/23 revealed, Resident #81 had an activity of	F 677	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ Resident #81 nails were cleaned and trimmed on 2/10/23 By the certified nursing assistant 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ A 100% audit was completed on all current residents by a Certified Nursing assistant to identify any residents in need of fingernails needing cleaning or trimmed. Any residents identified; nails were cleaned and trimmed. Audit was completed by 3/6/23. 3. Address what measures will be put	3/10/23

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daily living (ADL) deficit related to physical functioning with weakness status post hemiplegia following a stroke. The interventions included, set up items for personal hygiene and give assistance in all phases of care.

An observation and interview with Resident #81 on 2/7/23 at 10:50 AM revealed Resident #81 was up, dressed, and sitting in his wheelchair. His nails were observed clean but untrimmed. Resident #81 had impaired speech related to his stroke but could indicate yes or no by nodding his head. When this surveyor asked Resident #81 to see his nails, he raised his left hand. The nails on his left hand were long, jagged, and extended 1/2 inch beyond his fingertips. When asked to show this surveyor his right hand, he tried to lift his right hand with his left hand. When asked if he could move the right hand, Resident #81 indicated "no" by nodding his head. His right hand was in a closed position and his nails were not visible. When asked if he was ok with the length of his nails, he nodded "no". When asked if he would like them trimmed, Resident #81 indicated "yes". When asked if staff regularly trimmed his nails, he indicated "no".

An observation on 2/8/23 at 11:45 AM revealed Resident #81 was dressed and sitting up in his wheelchair. The nails on his left hand remain untrimmed, jagged, and extended 1/2 inch beyond his fingertips. A family member helped the resident open his hand. The nails on his right hand were not long and extended to the tips of his fingers.

During and interview on 2/8/23 at 11:50 AM Resident #81's family member revealed the resident was in the facility related to a stroke. He

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into place or systemic changes made to ensure that the deficient practice will not recur:
The administrator educated the interdisciplinary team to observe the condition of each resident□s fingernails during their ambassador rounds and identify any residents in need of nail care and report findings during daily meeting Monday through Friday. Weekend manager to do random audits of 5 residents each weekend for 8 weeks regarding nail care to identify any residents in need of nails being trimmed or cleaned and report findings to the Administrator. Staff development Coordinator educated the Certified nursing assistant to clean and trim the residents□ nails during showers and ADL care. Report to the nurse when a resident refuses. Education was completed by 3/6/23. Staff will not be permitted to work until education is completed. New hires will be educated on topic during orientation.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Nurse managers will audit 5 residents to identify residents in need of nailcare and verify that nails are clean and trimmed. Audits will be completed 5xper week for 4 weeks; 3xper week for 4 weeks; then 1xper week for 4 weeks. The Director of nursing will report results of the audit to the monthly Quality Assurance and Performance Improvement committee x3

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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 677	Continued From page 44 had difficulty with speech and providing care for himself related to not being able to use his right arm and leg. She stated the facility does not trim his nails. She further stated if his nails needed to be trimmed, she sometimes brought nail clippers and trimmed them herself. She stated if she had some nails clippers with her, she would trim his nails. An observation on 2/9/23 at 11:25 AM revealed Resident #81 was sitting up in his wheelchair dressed at the nurse station. The nails on his left hand remained untrimmed, jagged, and extended 1/2 inch beyond his fingertips. An interview and observation were conducted on 2/9/23 at 11:56 AM with Nurse #2. Nurse #2 revealed Resident #81 had difficulty with speech but could communicate through gesturing. He required extensive assistance with activities of daily living. He further revealed Resident #81 was pleasant and did not refuse care. Resident #81's nails were observed by Nurse #2, and he stated "yeah, they're long". Nurse #2 asked Resident #81 would he like his nails trimmed. Resident #81 raised his left hand to show his nails and nodded "yes". Nurse #2 stated resident's nails should be trimmed when needed and it could be done by the nurse aide or nurse. He further stated he did not know the resident's nails needed to be trimmed and he would ensure it was done. An interview with the Director of Nursing and the Corporate Nurse Consultant on 2/10/23 at 5:25 PM revealed nurses and nurse aides provided nail care and residents should be provided nail care with ADL care and as needed.	F 677	months or until substantial compliance is obtained and maintained.	

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F 688	Continued From page 45	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to order and apply a right resting hand splint to prevent further contracture for 1 of 1 resident reviewed for limited range of motion. (Resident #81) The findings included: Resident #81 was admitted to the facility on 7/13/22 with diagnoses that included stroke, hemiplegia and hemiparesis of the right side. A quarterly Minimum Data Set for Resident #81 dated 10/17/22 revealed the resident was cognitively impaired with no refusals or rejection of care. He received Occupational therapy (OT)	F 688	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ Resident #81 a therapy referral was given to therapy on 2/8/23 for contracture management by the Regional Nurse Consultant. On 2/13/23 an order was written for Occupational Therapy to eval and treat per POC. On 2/20/23 an order was written for nursing to apply a Right T-Bar splint 4 □6 hours daily. Monitor for skin changes or concerns. 2. Address how the facility will identify other residents having the potential to be	3/10/23

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F 688

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from 7/14/22 through 8/11/22 and Physical Therapy from 7/15/22 through 9/8/22. There was no orthotic use documented.

The care plan for Resident #81 updated on 1/26/23 revealed, Resident #81 had an Activities of Daily Living deficit related to physical functioning with weakness status post hemiplegia following a stroke.
The interventions included right resting hand splint as tolerated.

A review the Physician orders revealed there was no order for a hand splint.

An observation and interview with Resident #81 on 2/7/23 at 10:50 AM revealed Resident #81 was up and dressed and sitting in his wheelchair. Resident #81 had impaired speech related to his stroke but could indicate yes or no by nodding his head. An observation was made of a blue splint laying on the foot of the resident's bed. When asked by this surveyor was the blue splint his, Resident #81 nodded "yes" and pointed to his right arm. When asked if staff put it on for him, he nodded "no". When asked if he could move the right hand, Resident #81 indicated "no."

An observation and interview on 2/8/23 at 11:45 AM revealed Resident #81 was sitting up in his wheelchair dressed. The resident was not wearing the splint. This surveyor asked if he wore his splint since I spoke with him the day before, Resident #81 nodded "no." When asked where his splint was, he opened his drawer on his nightstand and showed the splint.

During an interview on 2/8/23 at 11:50 AM Resident #81's family member revealed he was in

F 688

affected by the same deficient practice:¿
All current residents with splint orders were verified with occupational therapy and the MD. Nurse management completed a 100% audit of residents with splints orders to verify orders were entered in the resident□s electronic record. Audit was completed by 3/6/23

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
The therapy department was educated by the Regional Nurse consultant to provide a copy of the therapy order to nurse management and nurse management will enter the order in the resident□s electronic record. Education was completed by 3/6/23. Nursing staff was educated to apply splints as ordered and document on the MAR/TAR, monitor for skin changes, certified nursing assistants to observe for changes in ADL performance during ADL care and report to the nurse, Licensed nurses to complete a therapy referral if changes in ADL performance is observed. Nurse management review therapy orders daily during clinical meeting 5 days a week to verify the order has been entered in the resident□s electronic record. Verified documentation of application. Care plan is updated. Education was provided by the Director of Nursing/ Staff development coordinator.
Education was completed by 3/6/23. Staff will not be permitted to work until

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F 688	Continued From page 47 the facility related to a stroke. He had difficulty with speech and providing care for himself related to not being able to use his right arm and leg. She stated the facility use to put on his splint at times, now they never put it on. An observation on 2/9/23 at 11:25 AM revealed Resident #81 was sitting up in his wheelchair dressed at the nurse station. Resident #81 was not wearing his splint. An interview and observation were conducted on 2/9/23 at 11:56 AM with Nurse #2. Nurse #2 revealed Resident #81 had difficulty with speech but could communicate through gesturing. He required extensive assistance with activities of daily living. He further revealed Resident #81 was pleasant and did not refuse care. Nurse #2 stated nurses were responsible for applying splint. He knew which residents needed a splint applied because it would appear on the resident's Medication Administration Record (MAR). Resident #81 was observed in his room in his wheelchair, he was not wearing his splint. Nurse #2 explained he was not aware Resident #81 needed an splint because it was not on his MAR. During an interview on 2/9/23 at 12:25 PM Occupational Therapy (OT) revealed Resident #81 received OT services from 7/14/22 through 8/12/22. They worked with the resident on transfers, dressing, and standing tolerance. OT further revealed there were contracture management goals. They worked on tolerance of a resting hand splint for Resident #81. She stated the resting hand splint was to prevent further contracture of his flaccid hand. OT explained once the resident built a tolerance for wearing the splint, nursing is trained for	F 688	education is completed. Any new hires will be educated on topic during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or the unit manager will audit during morning meeting that therapy orders for splints has been entered in the resident's electronic record and documentation of application 5xper week for 4weeks; 3xper week x4 weeks; than 1x per week for 4 weeks. The Director of nursing will report the results of the monthly audit to the Quality Assurance Performance Improvement Committee for the duration of x3 months or until substantial compliance is achieved and maintained.	

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management of the device. They provided training on device placement, wearing schedule, and how to recognize signs of improper fit. She further explained their process for entering orders at the time Resident #81 received his splint. The order was written on an order sheet by therapy, that then went to nursing. Nursing would enter the order and place the order sheet in the resident's chart for the physician to sign. OT revealed after a resident is discharged from therapy nursing is responsible for management of the splinting device. If nursing thought there was an issue with the fit or comfort, they could submit a therapy referral for the resident and therapy would re-evaluate. She stated when Resident #81 was discharged, OT recommended he wear the resting hand splint for up to 6 hours. Resident #81 was cooperative and wearing his splint for about 4 hours at discharge.

During an interview on 2/9/23 at 12:37 PM the Therapy Director revealed their old process for ordering splint was, therapy would write the order on an order sheet. The order sheet was then placed on the chart and flagged for nursing to enter and the physician to sign. She explained that at the time Resident #81 received his device they had new staff that were not familiar with the process. She stated she checked Resident #81's chart and could not find the order. She thinks they forgot place an order in the chart. She stated she would add a referral so Resident #81 could be re-evaluated.

An interview with the Director of Nursing and the Corporate Nurse Consultant on 2/10/23 at 5:25 PM revealed they were not aware that Resident #81 did not have an order for his splint and there should have been an order.

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F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide 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 observations, record review and interviews with staff and Resident #104, the facility failed to assist Resident #104 in his application for special transit service from Charlotte Area Transportation Service Americans with Disability Act Paratransit Service (a transportation service for persons with a disability). This failure occurred for 1 of 1 sampled resident reviewed for provision of medically related social services (Resident #104). The findings included: Resident #104 was admitted to the facility 8/5/22 and re-admitted to the facility on 2/6/23. Diagnoses included legal blindness, among others. An 8/12/22 admission Minimum Data Set (MDS) assessment for Resident #104 assessed him with severely impaired vision, and his cognition was intact. A care plan dated 8/16/22 identified Resident #104 was blind with difficulty navigating within his environment and though he may need assistance, he preferred to be as independent as possible. The goal was for Resident #104 to participate in activities as independent as possible per his request. Interventions included to offer Resident #104 outside and special event	F 745	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ As of 2/09/2023 application for resident #104 has been submitted by Administrator. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ All residents with disabilities have the potential to be affected by this deficient practice. As of 3/6/2023 a 100% audit of all residents with disabilities has been completed by the Social Worker. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 3/06/2023 Administrator has re-educated Social Workers on the process for completing American with Disabilities Act Paratransit Service for residents who request this service. Administrator will review all request weekly for 3 months to ensure applications are completed and submitted in a timely manner.	3/10/23

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activities.

A 12/7/22 quarterly MDS assessment for Resident #104 assessed him with severely impaired vision, and his cognition was intact. He was assessed to require set up help only from 1 staff for transfers and ambulation, and he did not use assistive devices to walk.

Resident #104 was interviewed on 2/7/23 at 2:21 PM. During the interview he was observed walking in his room using a walking stick to navigate the parameters of his room. Resident #104 stated that he completed an application online to receive special transit service, a transporation service for persons with a disability, which would allow him more independence and reduced cost transportation. The application also required a form to be completed by the physician, which had been given to the Administrator about 2 weeks ago and had not yet been completed. He stated the Administrator told him that the form had not been completed because the facility felt he was unsafe.

Resident #104 was observed on 2/10/23 at 12:40 PM to open/close his room door and walked out of his room down the hallway navigating the parameters of the hallway with his walking stick.

An interview on 2/10/23 at 9:30 AM with Nurse Aide #3 revealed she was assigned to care for Resident #104 often. She described him as independent with most of his care and stated he used a walking stick for assistance in his room and the facility.

Social Worker #1 was interviewed on 2/9/23 at 4:36 PM and stated Resident #104 had a new

F 745

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan.

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diagnosis of legal blindness and since admission to the facility he had learned to be more independent and had recently received a walking stick that he used in his room and in the facility. She stated she was aware he had applied for special transit service and that the physician was to complete part of the application.

During an interview on 2/7/23 at 3:28 PM, the Administrator stated he had received the physician's form for the special transit service on approximately 1/11/23. He stated he gave the form to the Nurse Practitioner (NP) to complete. During the interview, the Administrator provided the special transit service form for review. The form was signed, but not dated by the physician, and otherwise incomplete. The form required diagnoses, cognition, disabilities, prognosis, and an assessment of the use of assistive devices, ability to balance/ambulate, and safety concerns with using the service independently.

The NP stated in an interview on 2/9/23 at 10:45 AM that somewhere around the third week of January 2023, she stopped providing service to Resident #104 at his request. The NP stated she received a form for the special transit service for completion from the Administrator, but since she no longer provided service to Resident #104, she made the physician aware that the form needed to be completed.

A phone interview with the physician on 2/8/23 at 4:30 PM revealed she was aware Resident #104 applied for special transit service and that the application process required a form to be completed by the physician. The physician stated she signed the form but did not complete it. The physician stated she expected the form to have

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F 745	Continued From page 52 been completed.	F 745		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and the Refrigeration Company Technician interview, the facility failed to keep refrigerated foods stored for use within safe temperature range, less than 41 degrees Fahrenheit (F), for 1 of 1 reach-in refrigerator and 1 of 3 nourishment refrigerators. The facility also failed to discard expired food items stored for use in the dry storage room. This practice had the potential to affect food served to residents. The findings included:	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ As of 2/13/2023 hinges have been replaced on refrigerator doors in kitchen by an outside contractor. As of 2/10/2023 the Maintenance Director replaced the refrigerator on North Hall nourishment room. Dietary Manager removed all expired foods from dry storage areas as of 2/10/2023.	3/10/23

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1. An observation on 2/7/23 at 10:05 AM with the Certified Dietary Manager (CDM), revealed the two-sided reach-in-refrigerator had an internal thermometer reading of 60 degrees on the left side and 49 degrees F on the right side. Butter (several small serving cups) and several milk (8 oz cartons) were stored in the refrigerator.

An interview with the CDM on 2/7/23 at 10:20 AM revealed the reach-in refrigerator temperatures may have increased when dietary staff left the doors open during removal of food items during meal preparation. She further revealed a refrigeration company replaced the torn gaskets (rubber seals) on both doors on 2/6/23.

An interview and observation with the CDM on 2/9/23 at 7:30 AM indicated the reach-in refrigerator left side door was slightly ajar and the temperature had a thermometer reading of 49 degrees F. Butter (4 large sized blocks), several milk (8 oz cartons), and 2 serving trays of prepared sandwiches (wrapped in plastic) food items were located in the refrigerator. The CDM stated the dietary staff may have inadvertently left the door slightly ajar when they closed it.

An observation and interview with the CDM on 2/9/23 at 9:35 AM revealed all food items were removed and placed in walk-in refrigerator due to internal temperatures over 41 degrees F in the reach-in refrigerator and until the refrigerator could be repaired to working order.

An interview with the Maintenance Director on 2/9/23 at 10:35 AM indicated he would contact the refrigeration company to request a return maintenance visit to diagnose and service the reach-in refrigerator.

F 812

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿
All areas with refrigerators have the potential to be affected by this deficient practice therefore all refrigerators have been checked for function and proper temperature range. All dry food storage areas have then potential to be affected by this deficient practice therefore the Dietary Manager has completed 100% audit of all dry food storage areas as of 3/6/2023.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
As of 3/06/2023 the Dietary manager has re-educated all dietary staff on proper temperature of refrigerators and removal of expired foods from dry storage areas. Dietary will monitor all refrigerators daily for 4 weeks then twice per week for 8 weeks.to ensure proper closer and temperature range. Dietary Manager will monitor all dry storage areas daily Monday through Friday for 4 weeks then 3 times for 8 weeks for expired foods.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Dietary Manager will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will

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An interview and observation with the CDM, Maintenance Director, Refrigeration Company Technician and Administrator on 2/10/23 at 1:50 PM revealed the vibration/ suction/momentum/ force when closing one of the doors on the reach-in-refrigerator, inadvertently caused the other door to open and caused the internal temperature to rise beyond 41 degrees F. As a result, the Refrigeration Company Technician stated they would order and install refrigerator door clamps to alleviate the problem of the doors not remaining closed to maintain a temperature of 41 degrees F or less.

An interview with the Administrator on 2/10/23 PM at 2:00 PM indicated he was recently made aware there was an issue with temperatures related to the reach-in refrigerator. He further indicated all foods were removed from the refrigerator and placed in another refrigerator. He was also made aware the refrigeration company planned to order necessary parts to alleviate the problem and he expected the refrigerator to return to working order after repair.

2. An observation on 2/9/23 at 10:44 AM of the North Nourishment Room refrigerator revealed a temperature of 49 degrees F. A temperature log for February 2023 that was located on top of the refrigerator further revealed temperatures from 2/5/23 through 2/8/23 were 43 degrees F, 44 degrees F, 42 degrees F, and 41 degrees F, respectively. Unopened liquid dietary supplements (4 cartons) and a four pack of apple sauce containers were in the refrigerator.

During an interview on 2/9/23 at 11:35 AM the Dietary Assistant (DA) #1 indicated he worked at

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F 812	Continued From page 55	F 812		

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the facility for 8 months and he was responsible for logging the February temperatures for the Nourishment Room refrigerators. He further indicated he was unaware the temperature needed to be 41 degrees F or below but may have been educated on food safety during orientation.

During an interview on 2/9/23 at 11:40 AM the Certified Dietary Manager (CDM) revealed she was unaware the North Nourishment Room refrigerator was malfunctioning or not maintaining a 41-degree F temperature. She expected dietary staff to report it to her and/or Maintenance. At that time any food or snacks would be removed and discarded. She further revealed all dietary staff had been educated on food safety and maintaining safe refrigerator temperatures, during orientation and in-service.

An interview with the Maintenance Director on 2/9/23 at 11:55 AM indicated he was made aware on 2/9/23 that the Nourishment Room refrigerator was malfunctioning and that he would defrost it or have it replaced if necessary.

An interview on 2/9/23 at 11:00 AM with Unit Coordinator #1 indicated it was the responsibility of Dietary to maintain the Nourishment refrigerators. She expected the temperature in the refrigerators to be below 41 degrees F.

An interview on 2/9/23 at 11:30 AM with the Regional Clinical Nurse Consultant revealed she was recently made aware of the malfunctioning Nourishment Room refrigerator temperatures and was in the process of discarding its contents (cartons of liquid dietary supplements and containers of applesauce) due to food safety

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F 812	Continued From page 56 risks. She expected Dietary staff to report unsafe refrigerator temperatures to maintenance and nursing staff. An interview with the Administrator on 2/10/23 at 9:00 AM indicated he was recently made aware that the North Nourishment Room refrigerator was malfunctioning. He further indicated that he expected all staff who encountered the refrigerator to report any malfunctioning to include internal temperature over 41 degrees F. He also expected maintenance to assess the malfunction, repair it and replace it if necessary. Any food or snacks should be discarded that were not stored at required temperatures. 3. An observation on 2/7/23 at 10:17 AM of the dry storage room with the Certified Dietary Manager (CDM), the following concerns were identified: a) A box of 8-inch flour tortilla bread had a manufacturer's expiration date of 2/2/23. b) An unopened plastic container (128 oz) of salad dressing had an expiration date of 12/29/22. An interview with the CDM on 2/7/23 at 10:20 AM revealed she was unaware the tortilla bread and salad dressing were expired. She further revealed she and all dietary staff were responsible for labeling/dating and discarding expired foods. An interview with the Administrator on 2/9/23 at 4:18 PM indicated he was not aware of the expired foods and that his expectation was for foods to be checked for expiration dates on a regular basis and discarded if expired.	F 812		
F 842 SS=B	Resident Records - Identifiable Information	F 842		3/10/23

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F 842	Continued From page 57	F 842		

CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert

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F 842	Continued From page 58 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have accurate physician information in the medical record for 7 of 7 sampled residents (Resident #42, #58, #15, #68, #76, #52, and #69). The findings included: 1. Resident #42 was admitted to the facility on 3/11/21.	F 842	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ As of 3/15/2023 residents #42, #58, #15, #68, #76, #52, and #69 medical record has been corrected to reflect the correct physician. 2. Address how the facility will identify	

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2. Resident #58 was admitted to the facility on 9/21/2020.

3. Resident #15 was admitted to the facility on 10/7/2022.

4. Resident #68 was admitted to the facility on 2/5/2022.

5. Resident #76 was admitted to the facility on 1/31/2022.

6. Resident #52 was admitted to the facility on 6/13/2019.

7. Resident #69 was admitted to the facility on 10/11/2019.

A review of the medical records for Residents #42, #58, #15, #68, #76, #52, and #69 revealed the previous Medical Director was no longer at the facility as of 10/22 and was still listed as primary care physician for these residents on the electronic face sheet and clinical providers section.

An interview with the Regional Nurse Consultant on 2/9/23 at 3:05 PM indicated she was unaware the name of the previous Medical Director was still listed on the medical records of residents and not updated to reflect the current Medical Director. She stated there may have been a system glitch in October 2022, when the change should have taken place. She further indicated she has since reached out to their Information Technical (IT) support team to correct the issue.

An interview with the Administrator on 2/10/23 at

F 842

other residents having the potential to be affected by the same deficient practice:¿
All residents have the potential to be affected by this deficient practice therefore, 100% of all residents' medical records have been completed by Medical Records to ensure all residents have the correct physician listed in their medical record.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Administrator has re-educated the Social Worker, Business Office Manager, Medical Records, and Admissions Director on the process for entering attending physician on resident face sheet. Medical Records Technician will audit all new admissions and re-admissions daily for 12 weeks to ensure physician is listed in their medical record c correctly.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Medical Record Technician will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan.

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F 842	Continued From page 60 3:40 PM revealed he was recently made aware that the previous Medical Director's name had not been changed to the current Medical Director on resident medical records. He further revealed the medical record should have been updated in October 2022, when the current Medical Director took over.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		3/10/23

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F 867	Continued From page 61 development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity	F 867		

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of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:

Based on observations, staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions for F 558 Reasonable Accommodations of Needs/Preferences, F 578 Formulate Advanced Directives, F 584 Safe, Clean, Comfortable, Homelike Environment, F 602 Free from Misappropriation and Exploitation, F 644 Coordination of Preadmission Screening and Resident Review, F 677 Activities of Daily Living Care Provided for Dependent Residents, F 812 Food Procurement, Store, Prepare, Serve - Sanitary, and F 842 Resident Records, Identifiable Information which were put into place during the complaint investigation survey of 2/19/21, the recertification and complaint investigation survey of 8/13/21, a revisit and complaint investigation survey of 11/10/21, the complaint investigation survey of 9/29/22, and on the current recertification and complaint investigation survey of 2/10/23. The continued failure of the facility during five federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program.

Findings included:

This tag is cross referenced to:

F 558 E: Based on observations, record reviews, resident, and staff interview the facility failed to provide a resident that was cognitively able to use a call bell with a specialty call bell or way to call

F 867

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
As of 3/06/2023 facility Quality Assurance Performance Improvement (QAPI) process has been corrected to effectively correct and monitor deficient areas. Regional Director of Operations re-educated the Administrator on the QAPI process to include review of prior survey citations and monitoring of citations.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All prior identified deficient citations have the potential to be affected by this deficient practice therefore, the Administrator has reviewed annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
As of 3/6/2023 Regional Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and process of

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for assistance without having to yell for 1 of 1 resident reviewed for accommodation of needs (Resident #87).

During the revisit and complaint investigation surveys of 11/10/21 the facility failed to provide a call light to accommodate 2 of 3 residents reviewed for accommodations.

F 578 D: Based on record review and staff interview the facility failed to have advance directive information available in the medication record for 2 of 3 residents reviewed for advance directives (Resident #212 and Resident #213).

During the recertification and complaint survey of 8/13/21 the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 1 resident reviewed for advanced directives.

F 584 D: Based on observations, record review, resident, and staff interview the facility failed to maintain a clean homelike environment for residents by failing to maintain an odor free environment for 3 of 3 halls (North, South and West). The facility also failed to clean the floor of a resident's room, provide bed linens, and repair a toilet in a resident room. (South hall).

During the recertification and complaint investigation survey of 8/13/21, the facility failed to maintain the walls in resident rooms in good repair for resident rooms on 3 of 3 halls; keep a toilet seat in good repair for 1 of 2 resident bathrooms; repair broken chairs in 1 of 1 dining room; ensure a baseboard was in place for 1 of 1 dining room wall; ensure a baseboard was in good repair for 1 of 1 resident room; ensure

F 867

removing monitoring of areas. Regional Director of Operations will review QAPI minutes monthly to ensure improvement and monitoring of areas of deficient practice. Administrator will review Plan of Correction during weekly AdHoc QAPI meeting to ensure no future repeats of prior tags for 8 weeks and then monthly for 12 months during monthly QAPI meeting.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan.

F 867 Continued From page 65 F 867

drawers in a resident's built in chest was in good repair for 1 of 1 resident room; ensure sanitary ceiling vents for 1 of 1 dining room; ensure a working overhead light was in place for 1 of 2 resident bathrooms.

F 602 D: Based on record review, resident interview, staff interviews and Pharmacist Consultant interview the facility failed to prevent drug diversion on 2 occasions for 1 of 3 residents reviewed for misappropriation of resident property (Resident #80).

During the recertification and complaint survey of 8/13/21, the facility staff failed to report a resident kept a large sum of money on his person which put him at high risk for abuse, exploitation, and misappropriation and failed to prevent misappropriation of resident property when the money was removed from his pant pocket and stolen by an individual for 1 of 5 residents reviewed for abuse.

F 644 E: Based on record reviews and staff interviews the facility failed to submit an update or make recommendations for Level II Preadmission Screening and Resident Review (PASRR) for 2 of 4 sampled residents (Resident #104 and Resident #42).

During the recertification and complaint survey of 8/13/21, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 1 resident reviewed with a Level II PASRR.

F 677 D: Based on observations, record review, resident, and staff interview the facility failed to provide nail care for 1 of 1 resident who was

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F 867	Continued From page 66 dependent on staff assistance for activities of daily living (Resident #81). During the complaint investigation survey of 9/29/22, the facility failed to provide care for an incontinent resident dependent on staff for toilet use and personal hygiene resulting in 2 new areas of moisture associated skin damage being identified for 1 of 3 residents reviewed for activities of daily living. During the revisit and complaint investigation survey of 11/10/21, the facility failed to provide hair wash and nail care to 1 of 3 dependent residents reviewed for activities of daily living. During the recertification and complaint investigation survey of 8/13/21, the facility failed to check for incontinence or provide incontinence care to 1 of 7 sampled residents dependent on staff for activities of daily living. F 812 E: Based on observations, record review, and staff interviews, the facility failed to discard expired food items stored for use in the dry storage room. This practice had the potential to affect food served to residents. During a revisit and complaint investigation survey completed on 11/10/21 the facility failed to label and date leftover food and residents' personal food items stored ready for use in 3 of 3 nourishment room refrigerators. During the recertification and complaint investigation survey of 8/13/21, the facility failed to maintain milk, a potentially hazardous food, 41 degrees Fahrenheit (F) or below on the lunch meal tray line, discard potentially hazardous	F 867		

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foods with signs of spoilage (iceberg lettuce, bell peppers, bananas), label and date opened food items (turkey breast, deli ham), store foods in a closed container (vegetable beef soup) and store bananas 56 - 60 degrees F per manufacturer recommendations in 1 of 1 refrigerator, freezer, and dry storage.

F 842 B: Based on record reviews and staff interviews the facility failed to have accurate physician information in the medical record for 7 of 7 sampled residents (Resident #42, #58, #15, #68, #76, #52, and #69).

During the recertification and complaint investigation survey of 8/13/21, the facility failed to maintain an accurate Medication Administration Record for the administration of oxygen no longer in use for 1 of 1 resident reviewed for respiratory care.

During a complaint investigation survey of 2/19/21 the facility failed to transcribe a physician's order, document regarding initiation of a new order, and document treatment provided by the facility into the medical record for 1 of 3 residents reviewed for change in condition.

During an interview with the Administrator on 2/10/23 at 1:22 PM, he stated quarterly QAPI meetings included a group discuss utilizing a corporate template that reviewed recurrent concerns, Resident Council meeting minutes, employee retention, trends, and the facility's four-point plan. He stated the committee discussed current problems and determined an approach or strategy to formulate a plan to address these concerns. He stated follow-up discussions occurred for the duration each

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F 867	Continued From page 68 agenda item was discussed in QAPI. He further clarified that some agenda items were discussed for 90 day or less depending on the severity of the concern. He stated that since the recertification and complaint survey of 8/13/21, the facility experienced quite a change in their leadership team which could have been a contributing factor to identifying repeat deficiencies. He further stated that staffing had improved and attributed that improvement to having fewer deficiencies on the current recertification survey compared to the one in 2021. He attributed the deficiency related to advanced directives to a change in Social Workers, the deficiencies related to accommodation of needs, ADL care, abuse, environment, food procurement, and PASRR to poor oversight, and the resident records to a poor facility response in updating electronic records.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		3/10/23

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F 883	Continued From page 69 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 883	1. Address how corrective action will be	

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F 883 Continued From page 70

facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Pneumococcal immunization and if residents received the Pneumococcal immunization or did not receive the Pneumococcal immunization due to medical contraindication or refusal for 5 of 5 residents reviewed for infection control (Resident #37, Resident #72, Resident #78, Resident #87, and Resident #106).

The findings included:

1. Resident #37 was admitted to the facility on 08/11/15.

The quarterly Minimum Data Set (MDS) dated 11/21/22 revealed that Resident #37 was severely cognitively impaired for daily decision making. The MDS further revealed that Resident #37 received the Pneumococcal immunization in the facility on 10/19/22 and was up to date.

A review of Resident #37's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical

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accomplished for those residents found to have been affected by the deficient practice:¿
As of 3/06/2023 residents #37, Resident #72 was discharged from the facility on 2/8/23, #78, 387, and #106 medical records have been updated by the Infection Preventionist to reflect education regarding benefits and potential side effects of the pneumococcal immunization and if residents received or did not receive pneumococcal immunization and along with consent or refusal.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿
All residents have the potential to be affected by the same deficient practice of failure to include in the resident□s medical record documentation of education provided regarding the benefits and potential side effects of receiving the pneumonia vaccine or consent forms indicating the acceptance or refusal of the pneumonia vaccine. All current residents had records reviewed and pneumonia consent information uploaded by Medical Records on 3/13/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
As of 3/6/ 23 The Regional Nurse consultant educated the admissions coordinator and the Infection preventionist and the Director of Nursing in the process

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record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Pneumococcal immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. The IP indicated she had been focusing on the Flu immunization and not the Pneumococcal immunization. She stated she had only been at the facility for two months and could not speak to information from prior to her time in the facility. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the pneumococcal immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process

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of obtaining consent for the pneumonia immunizations upon admission. The admissions coordinator will give the signed consent to the IP nurse and the IP nurse will ensure an order is obtained and the vaccine is administered and entered in the resident□s medical record as given. The IP Nurse will give the consent form to medical Records to scan into the resident□s medical record. Staff will not be permitted to work until education is complete. New hires will be educated on topic during education.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Nursing will audit new admissions to verify that consents are obtained for pneumonia immunizations, orders are obtained for administration, Documentation of administration is entered in the residents□ electronic record and the consent form has been scanned into the resident□s electronic record. Audit will be conducted 5xper week for 4weeks; 3xper week for 4 weeks; then 1xper week for 4weeks. The results of the audit will be reported by the Director of Nursing to the Quality Assurance and Performance Improvement Committee monthly x3months or until substantial compliance is achieved and maintained.

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F 883	Continued From page 72	F 883		

was as far as immunizations. He stated that the IP took care of that information.

2. Resident #72 was admitted to the facility on 01/04/23 and was discharged home on 02/08/23.

Review of the comprehensive admission Minimum Data Set (MDS) dated 01/13/23 revealed that Resident #72 was cognitively intact, and his pneumococcal immunization was not up to date but did not indicate a reason.

A review of Resident #72's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all Immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

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F 883	Continued From page 73 A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Pneumococcal immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. The IP indicated she had been focusing on the Flu immunization and not the Pneumococcal immunization. She stated she had only been at the facility for two months and could not speak to information from prior to her time in the facility. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the pneumococcal immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record. The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information. 3. Resident #78 was admitted to the facility on 10/16/20. Review of the quarterly Minimum Data Set (MDS) dated 11/02/22 indicated that Resident #78 was severely cognitively impaired for daily decision making and indicated that Resident #78's pneumococcal immunization was up to date.	F 883		

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A review of Resident #78's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Pneumococcal immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. The IP indicated she had been focusing on the Flu

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F 883	Continued From page 75	F 883		

immunization and not the Pneumococcal immunization. She stated she had only been at the facility for two months and could not speak to information from prior to her time in the facility. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the pneumococcal immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.

4. Resident #87 was readmitted to the facility on 01/02/23.

Review of the quarterly Minimum Data Set (MDS) dated 01/13/23 indicated that Resident #87 was severely cognitively impaired for daily decision making and indicated his pneumococcal immunization was up to date.

A review of Resident #87's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

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F 883	Continued From page 76 An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record. The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022. A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Pneumococcal immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. The IP indicated she had been focusing on the Flu immunization and not the Pneumococcal immunization. She stated she had only been at the facility for two months and could not speak to information from prior to her time in the facility. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the pneumococcal immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination	F 883		

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then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.

5. Resident #106 was admitted to the facility on 11/03/22.

Review of the comprehensive significant change Minimum Data Set (MDS) dated 12/15/22 indicated that Resident #106 was severely cognitively impaired and indicated that his pneumococcal vaccination was not up to date but did not give a reason as to why not.

A review of Resident #87's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she

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F 883	Continued From page 78 received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022. A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Pneumococcal immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. The IP indicated she had been focusing on the Flu immunization and not the Pneumococcal immunization. She stated she had only been at the facility for two months and could not speak to information from prior to her time in the facility. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the pneumococcal immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record. The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.	F 883		
F 887 SS=E	COVID-19 Immunization	F 887		3/10/23

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F 887	Continued From page 79 CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with	F 887		

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F 887	Continued From page 80 COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 5 of 5 residents reviewed for infection control (Resident #37, Resident #72, Resident #78, Resident #87, and Resident #106). The Findings included: 1. Resident #37 was admitted to the facility on 08/11/15. A review of Resident #37's medical record revealed there was no information documented in the Resident's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the	F 887	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿ The facility failed to include in the resident□s medical record documentation of education provided regarding the benefits and potential side effects of receiving the Covid 19 vaccine or consent forms indicating the acceptance or refusal of the Covid 19 vaccine for Residents #3, #37, #72, #78, ,87, and #106. Consent forms have been placed in the medical record for Residents 3, #37, #72, #78, ,87, 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿	

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COVID-19 vaccine.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Covid-19 immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. She stated that they had a Covid-19 vaccination clinic about every month at the facility. They would obtain the consents then pharmacy staff would come in and administer the vaccine. The IP stated she thought she had been giving the consent forms to the Medical Record Clerk to upload in the medical record. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the Covid-19 immunization

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All residents have the potential to be affected by the same deficient practice of failure to include in the resident�s medical record documentation of education provided regarding the benefits and potential side effects of receiving the Covid 19 vaccine or consent forms indicating the acceptance or refusal of the Covid 19 vaccine. All current residents had their records reviewed and Covid 19 consent information uploaded by Medical Records on 3/13/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Education began and was completed on 3/13/23 on facility policy for Covid 19 specific to documentation of education provided regarding the benefits and potential side effects of receiving the Covid vaccine or consent forms indicating the acceptance or refusal of the vaccine. Education completed by the Director of Nursing to members of Nurse Management inclusive of the Staff Development Coordinator, MDS nurses, Staff Development Coordinator, and Infection Control Nurse. Other members in attendance included the Social Work and Admissions Director.
Audit will be completed weekly of all new admissions to ensure that Covid 19 education was provided to newly admitted residents regarding the benefits and potential side effects of receiving the vaccine. The consent form indicating acceptance or refusal of the vaccine has

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and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.

2. Resident #72 was admitted to the facility on 01/04/23 and was discharged home on 02/08/23.

A review of Resident #72's medical record revealed there was no information documented in the Resident's medical record that the Resident or legal representative was provided information about the benefits
and potential side effects of the COVID-19 vaccine.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

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been uploaded into the resident specific medical record. Weekly audits will be completed by the Administrator ongoing for a period of 12 weeks to ensure compliance with facility policy.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Nursing is responsible for implementing this plan of correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but is not limited to, the Director of Nursing, Administrator, MDS Coordinator, Assistant Director of Nursing, Social Worker, Activities Director, Dietary Manager, Maintenance Director, Medical Records, and Medical Director. The audits will be reviewed monthly and recommendations for changes of the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance.

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A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Covid-19 immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. She stated that they had a Covid-19 vaccination clinic about every month at the facility. They would obtain the consents then pharmacy staff would come in and administer the vaccine. The IP stated she thought she had been giving the consent forms to the Medical Record Clerk to upload in the medical record. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the Covid-19 immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.

3. Resident #78 was admitted to the facility on 10/16/20.

A review of Resident #78's medical record revealed there was no information documented in the Resident's medical record that the Resident

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F 887	Continued From page 84 or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine. An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record. The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022. A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Covid-19 immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. She stated that they had a Covid-19 vaccination clinic about every month at the facility. They would obtain the consents then pharmacy staff would come in and administer the vaccine. The IP stated she thought she had been giving the consent forms to the Medical Record Clerk to upload in the medical record. The Regional Clinical Nurse Consultant stated that the process began on admission. The	F 887		

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F 887	Continued From page 85 staff should be attempting to determine the resident's history of the Covid-19 immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record. The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information. 4. Resident #87 was admitted to the facility on 01/02/23. A review of Resident #87's medical record revealed there was no information documented in the Resident's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine. An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record. The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any	F 887		

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information since October 2022.

A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Covid-19 immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. She stated that they had a Covid-19 vaccination clinic about every month at the facility. They would obtain the consents then pharmacy staff would come in and administer the vaccine. The IP stated she thought she had been giving the consent forms to the Medical Record Clerk to upload in the medical record. The Regional Clinical Nurse Consultant stated that the process began on admission. The staff should be attempting to determine the resident's history of the Covid-19 immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record.

The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.

5. Resident #106 was admitted to the facility on 11/03/22.

A review of Resident #106's medical record revealed there was no information documented in

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the Resident's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine.

An interview was conducted with the Infection Preventionist (IP) on 02/07/23 at 3:25 PM who stated that she obtained the consents for all immunizations and then once the vaccine was given, she would give the consents to the Medical Record Clerk to be uploaded in the medical record.

The Medical Record Clerk was interviewed on 02/07/23 at 3:55 PM. She stated that once she received the immunization consents or declinations, she would immediately upload the document into the medical record. She further indicated she had not received any consents or declinations and had not uploaded any information since October 2022.

A follow up interview was conducted with the IP and the Regional Clinical Nurse Consultant on 02/10/23 at 11:20 AM. The IP stated that when a new resident admitted to the facility, she would go through the packet of information to see if they had received the Covid-19 immunization outside of the facility and then would call the Responsible Party or speak to the Resident if the information was not in the packet of information provided upon admission to the facility. She stated that they had a Covid-19 vaccination clinic about every month at the facility. They would obtain the consents then pharmacy staff would come in and administer the vaccine. The IP stated she thought she had been giving the consent forms to the Medical Record Clerk to upload in the medical record. The Regional Clinical Nurse Consultant

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F 887	Continued From page 88 stated that the process began on admission. The staff should be attempting to determine the resident's history of the Covid-19 immunization and then the IP should be following up with the resident or responsible party and providing the education and obtaining consent or declination then that information should be uploaded to the resident's medical record. The Director of Nursing (DON) was interviewed on 02/10/23 at 2:32 PM. The DON stated he was still in training and was not sure what the process was as far as immunizations. He stated that the IP took care of that information.	F 887		