STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING ______ B. WING ______	C 01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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E 000	Initial Comments An unannounced Recertification and complaint survey was conducted on 01/23/23 through 01/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 3R3911.	E 000		
F 000	INITIAL COMMENTS A recertification, complaint investigation, and revisit follow up survey were conducted from 01/23/23 through 01/27/23. Event ID# 3R3911 and Event ID 6GKY12. Tags F580, F742, and F925 were corrected as of 1/27/23. However, new tag was cited as a result of the recertification /complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID 6GKY12. The following intakes were investigated Please select one of the followings: NC00197413 ; NC00197354 ; NC00197257; NC00196967; NC00196751; NC00196610; NC00196441; NC00194774; NC00193414; NC00192880; NC00191317; NC00190317; NC00190207; NC00190209; NC00189008; NC00188556; NC00188551: NC00188412 ; and NC00188065 14 of the 46 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		3/6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/20/2023

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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F 550	Continued From page 1 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation resident	F 550	Maple Grove Health and Rehabilitation	

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F 550	Continued From page 2 and staff interviews the facility failed to treat Resident #392, 1 of 1 resident reviewed for catheter care, with dignity. The facility failed to have Resident #239's catheter bag covered for privacy and dignity. The findings included: Review of Resident #392's medical record revealed she was originally admitted to the facility on 8/24/22 with most recent readmission on 01/13/23. Her diagnoses included chronic kidney disease, sepsis, urinary tract infection. Review of Resident #392's Minimum Data Set (MDS) assessment dated 8/24/22 revealed she was cognitively intact and required supervision to extensive assistance with all activities of daily living, such as, turning in bed, transferring, eating, toileting, bathing, and personal hygiene. Resident #392 also required an indwelling urinary catheter. On 01/23/23 at 12:04 PM Resident #392 was observed sitting in her wheelchair in the doorway of her room. Her catheter bag was hanging from the side of her wheelchair with the bag uncovered. From the hallway the catheter bag was observed to contain dark amber urine. No privacy bag observed on the wheelchair or in the Resident's room. On 01/23/23 at 12:50 PM Resident #392 was observed ambulating in her wheelchair in the hallway with the uncovered urine catheter bag hanging from her wheelchair. Dark amber urine was again visible due to no privacy cover on the urine catheter bag. During an interview and observation on 01/23/23	F 550	Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven 526.43 Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights Resident #239 (on sample list of residents is identified as #392) indwelling urinary catheter bag was covered, this was completed by the Director of Nursing on 1/23/23. On 1/23/23, the Director of Nursing initiated an audit of all residents with urinary catheter bags to ensure they were covered. The Director of Nursing (DON) and/or Assistant Director (ADON) of Nursing will address all concerns identified through the audit.	

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F 550	Continued From page 3	F 550		

at 3:24 PM Resident #392 was observed in her wheelchair in the vending area. Her catheter bag was enclosed in a privacy bag. She revealed the catheter bag was covered after staff observed surveyors looking at her catheter bag in the hallway. She further revealed the catheter bag had not been covered since her admission. She stated she would have liked for her catheter bag to have been covered since her admission so that her urine was not visible to other residents and visitors.

An interview with NA #7 on 01/26/23 at 3:26 PM revealed she was typically assigned to Resident #392's hall and was familiar with the Resident. She said she did not remember a time when the Resident's urine catheter bag was covered with a privacy bag. NA #7 stated she would normally make sure the bag was below the bladder, free of kinks and covered in a privacy bag. She further stated she observed a resident with an uncovered catheter bag, she could obtain a bag from central supply or ask a nurse for one.

During an interview with the Senior Administrator on 01/26/23 at 3:26 PM revealed there should be no reason for a resident not to have a privacy cover on their catheter bag. She stated her expectation was urine catheter bags would be covered at all times with a privacy bag to ensure the resident's privacy was protected.

In an interview with the facility Administrator on 01/27/23 at 10:10 AM he stated that the facility did not want the Resident's urine to be in plain sight. He further stated it was his expectation for catheter bags to be covered with a privacy cover to maintain the Resident's dignity and privacy.

On 2/14/23 the DON/ADON initiated an in-service with all nurses, and nursing assistants, to include agency and contract staff on covering urinary catheter bags to maintain dignity and privacy In-service will be completed by 3/6/23. After, 3/6/23 any nurses, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding covering urinary catheter bags.

An audit of all residents with urinary catheter bags will be completed by the DON/ADON and/or Unit Manager (UM) 1 time weekly x 4 weeks, then monthly x 2 month utilizing the audit tool. This audit is to ensure all residents with urinary catheter bags have their bags covered appropriately. The DON will address all concerns identified during the audit to include re-training of nursing staff.

The Director of Nursing will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Urinary Catheter Bag Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

Date of Alleged Compliance 3/6/23

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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. (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 record review, resident and staff	F 565	F565 Resident/Family Group Response	3/6/23

F 565 Continued From page 5

interviews, and review of the Resident Council Minutes, the facility failed to record and respond to concerns voiced by residents during Resident Council meetings for 8 of 12 months (April, May, July, August, September, October, November and December 2022).

Findings included:

The Resident Council minutes were reviewed for April, May, July, August, September, October, November and December 2022 and revealed no concerns or grievances were documented from residents. The minutes indicated Resident #18, Resident #32, Resident #47, Resident # 48, Resident#52, Resident #67, Resident #73, Resident #87 and Resident # 392 attended these meetings. The identified Residents were interviewable with a BIMS (brief interview mental status) greater than 11.

On 01/24/23 at 10:30 am a Resident Council meeting was held and attended by Resident #67, Resident #48, Resident # 86, Resident #392, Resident #18, Resident #47, Resident #52, Resident #50, Resident #65 and Resident #73. During the meeting the residents were notified that based on review of the Resident Council minutes for April, May, July, August, September, October, November and December no concerns were voiced by the residents. The residents in attendance reported this was not true and that concerns had been reported each meeting for the last year. Resident #48 stated that concerns with smoking, staffing, food, bathing and missing items were ongoing concerns that had been reported for months. The residents stated the Activity Director told them at the beginning of each meeting grievances and concerns were not

F 565

On 1/25/23 the Administrator reviewed the grievance log for resident council grievances, that were not in the resident council minutes. The Administrator found grievances from Residents #18, #32, #47, #48, #52, #67, #73, #87 and #392 from resident council that had been written on the facility concern forms instead of recorded on the Resident Council Meeting Minutes from April, May, July, August, September, October, November and December. The Administrator was able to determine the grievances were investigated and a resolution was obtained on the resident council concerns.

On 1/25/23 the Administrator provided the Activities Director with a copy of the Resident Council Grievance Follow-up form. This form is to be used for the Resident Council Grievances lodged during the Resident Council Meeting.
On 2/24/23 the Administrator completed an in-service for the Activities Director on the correct forms to use for the Resident Council Meeting Minutes, on including any grievances or concerns from the council meeting in the minutes and using the Resident Council Grievances Follow-up form. New Activities Director hired after 2/24/23, will be in-serviced during orientation regarding Resident Council Meeting Minutes, on including any grievances or concerns from the council meeting in the minutes and using the Resident Council Grievances Follow-up.

The Administrator will audit 1 time monthly

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F 565	Continued From page 6 reported in the minutes. The residents also stated that their concerns had not been addressed and they were unaware of efforts to resolve their concerns as they remained ongoing. During the meeting, Resident # 32 explained the Council Members voiced grievances and concerns during the meetings, however the concerns and grievances were never resolved by the facility. Resident #32 added the facility has had five Administrators within the year, and nothing was being done for our concerns. During an interview with the Activity Director on 01/24/23 at 4:00 pm, the Activity Director stated she oversaw the Resident Council meetings and documented the minutes but not concerns or grievances. She stated she was told by the Administrator not to document concerns and grievances in the minutes but on a separate concerns form. The Activity Director provided the January 2023 concern form from the Resident Council meeting and no concerns were recorded. The Administrator was interviewed on 01/26/23 at 1:13 pm. The Administrator indicated that the Resident Council members could voice grievances and concerns in the meeting but if there were private issues, they were having they could come to him or the SW individually. He stated he did attend the Resident Council meeting in January 2023. He indicated that he expected the residents to feel free to voice their concerns and grievances, during their Resident Council meetings and any concerns or grievances to be documented in the Council minutes as well as a grievance form filed.	F 565	x 3 months utilizing Audit Tool. This audit is to ensure all resident grievances and concerns are being recorded appropriately in the meeting minutes for review at each meeting. The Administrator will address all concerns identified during the audit to include re-training of Activities Director. The Administrator will present the findings of the Resident Council Grievance Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Resident Council Grievance Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 3/6/23	
F 623 SS=B	Notice Requirements Before Transfer/Discharge	F 623		3/9/23

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CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs,

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under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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F 623	Continued From page 9 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the resident and/or Responsible Party (RP) written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization (Residents #342, #442 and #80). The findings included: 1. Resident #342 was admitted to the facility on 03/23/2022. A Modification of Admission Minimum Data Set (MDS) assessment dated 03/30/2022, indicated Resident #342 was cognitively intact. A review of Resident #342's medical record revealed she was transferred to the hospital on 04/24/2022 for nausea and vomiting and was expected to return to the facility. There was no	F 623	F623 Requirements Before Transfer/Discharge On 2/13/23, the Director of Nursing initiated an audit of resident #342, #442 and #80 discharged to determine if the notice of acute discharge notice was completed and given to the resident and sent to the resident representative. The Director of Nursing (DON) and/or Assistant Director (ADON) of Nursing will address all concerns identified through the audit. Resident #342, #442 and #80 have all passed away. On 2/13/23, the Corporate Clinical Director and Social Worker initiated an audit of all residents discharged in the last 30 days to determine if the acute discharge notice was completed and	

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F 623	Continued From page 10 documentation that a written notice of transfer was provided to the resident and/or the RP for the reason of the transfer. On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the nurses ' responsibility to send the notification in writing to the resident and family for the reason of the discharge to the hospital. On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP). She stated it was the nurses ' responsibility to send the notification in writing to the resident and RP for reason of a discharge to the hospital. On 01/26/23 at 12:16 PM an interview was conducted with the Clinical Director. She stated she was unable to locate notification in writing of discharge to the hospital for Resident #342 ' s hospital transfer on 04/24/2022. On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the written notice of transfer for the resident and/or the RP. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager	F 623	given to the resident and sent to the resident representative. The DON/ADON will address all concerns identified through the audit. On 2/14/23 The DON/ADON in-serviced the nurses and Social Worker to include agency and contract staff on the Acute Discharge Notice is to be completed when the resident is transferred to the hospital for an acute issue. The form must be given to the resident by the nurse and sent to the resident representative by the Social Worker when the resident is transferred to an acute care hospital. The in-service will be completed 3/6/23. After 3/6/23 any nurses, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding the Acute Discharged Notice form. The DON/ADON will audit 1 times weekly x 4 weeks, 1-time monthly x 2 months utilizing the Audit Tool. This audit is to ensure all resident transferred or discharged to the hospital are given the Acute Discharge Notice From and it is sent to the resident representative. The DON will address all concerns identified during the audit to include re-training of nurses. The DON will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI)	

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MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

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F 623	Continued From page 11 would send that information to the RP. On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy or a written notice of transfer for the resident and/or RP. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family. On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the resident to the hospital. The folder did not list a written reason for transport for the resident or the RP. On 01/27/2023 at 10:00 AM an interview was conducted with the Senior Administrator. She stated the facility had not been sending written notification of a hospital transfer to the resident or the RP. She also stated the facility was unaware the written notification was to be sent. On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the business office was to follow up with family the day after the hospital transfer by phone and they are to send a written letter to the RP giving the reason for the transfer.	F 623	committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Transfer/Discharge/Bed Hold Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of alleged compliance 3/6/23	

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F 623	Continued From page 12	F 623		

2. Resident #442 was admitted to the facility on 08/24/22.

Resident #442's medical record revealed he was transferred to the hospital on 11/10/2022. There was no documentation that a written notice of transfer was provided to the resident and/or the RP for the reason of the transfer.

A Significant Change Minimum Data Set (MDS) assessment dated 11/28/2022, indicated Resident #442 was severely cognitively impaired.

On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the
nurses ' responsibility to send the notification in writing to the resident and family for the reason of the discharge to the hospital.

On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection
Control Preventionist (ADON/ICP). She stated it was the nurses ' responsibility to send the notification in writing to the resident and RP for reason of a discharge to the hospital.

On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the written

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F 623	Continued From page 13	F 623		

notice of transfer for the resident and/or the RP. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to the RP.

On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy or a written notice of transfer for the resident and/or RP. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family.

On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the
resident to the hospital. The folder did not list a written reason for transport for the resident or the RP.

On 01/27/2023 at 10:00 AM an interview was conducted with the Senior Administrator. She stated the facility had not been sending written notification of a hospital transfer to the resident or the RP. She also stated the facility was unaware the written notification was to be sent.

On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the business
office was to follow up with family the day after the hospital transfer by phone and they are to

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F 623	Continued From page 14 send a written letter to the RP giving the reason for the transfer. 3. R Resident #80 was admitted to the facility on 11/08/22. Resident #80's medical record revealed she was transferred to the hospital on 01/11/22 for a nosebleed. There was no documentation that a written notice of transfer was provided to the resident and/or the RP for the reason of the transfer. A Significant Change Minimum Data Set (MDS) assessment dated 01/13/23, indicated Resident #80 was severely cognitively impaired. On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the nurses ' responsibility to send the notification in writing to the resident and family for the reason of the discharge to the hospital. On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP). She stated it was the nurses ' responsibility to send the notification in writing to the resident and RP for reason of a discharge to the hospital. On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information	F 623		

F 623 Continued From page 15 F 623

on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the written notice of transfer for the resident and/or the RP. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to the RP.

On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy or a written notice of transfer for the resident and/or RP. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family.

On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the
resident to the hospital. The folder did not list a written reason for transport for the resident or the RP.

On 01/27/2023 at 10:00 AM an interview was conducted with the Senior Administrator. She stated the facility had not been sending written notification of a hospital transfer to the resident or the RP. She also stated the facility was unaware the written notification was to be sent.

On 01/27/23 at 11:13 AM an interview was

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F 623	Continued From page 16 conducted with the Administrator. He stated the business office was to follow up with family the day after the hospital transfer by phone and they are to send a written letter to the RP giving the reason for the transfer.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		3/9/23

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This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to provide notice of the bed hold policy
prior to transfer for 3 of 3 resident reviewed for hospitalizations (Residents #342, #442, #80).

The findings included:

1. Resident #342 was admitted to the facility on 03/23/2022.

A Modification of Admission Minimum Data Set (MDS) assessment dated 03/30/2022, indicated Resident #342 was cognitively intact.

A review of Resident #342's medical record revealed she was transferred to the hospital on 04/24/2022 for nausea and vomiting and was expected to return to the facility. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party.

On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the
nurses ' responsibility to send the bed hold policy to the hospital with the resident at time of transfer.

On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection
Control Preventionist (ADON/ICP). She stated it was the nurses ' responsibility to send the bed hold
policy to the hospital with the resident at time of transfer.

F 625

F625 Notice of Bed Hold Policy Before/Upon Transfer

On 2/13/23, the Director of Nursing initiated an audit of resident #342, #442 and #80 discharged to determine if the notice of Bed Hold Policy was completed and given to the resident and/or discussed with the resident representative. The Director of Nursing (DON) and/or Assistant Director (ADON) of Nursing will address all concerns identified through the audit. Resident #342, #442 and #80 have passed away.

On 2/14/23, the Corporate Clinical Director and Social Worker initiated an audit of all residents discharged in the last 30 days to determine if the Bed Hold Policy notice was completed and given to the resident and sent to the resident representative. The DON/ADON will address all concerns identified through the audit.

On 2/14/23 The DON/ADON in-serviced the nurses to include agency and contract staff on the Bed Hold Policy to be completed when the resident is transferred to the hospital for an acute issue. The form must be given to the resident and discussed with the resident representative when the resident is transferred to an acute care hospital, the floor nurse will be responsible for giving the resident the bed hold and the Business Office Manager will discuss with

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F 625	Continued From page 18 On 01/26/23 at 12:16 PM an interview was conducted with the Clinical Director. She stated she was unable to locate documentation that the bed hold policy for Resident #342 ' s was sent with her during the hospital transfer on 04/24/2022. On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the bed hold policy. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the resident and/or the Responsible Party. On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family.	F 625	the family. The in-service will be completed by 3/6//23 After 3/6/23, any nurses, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding the Bed Hold Policy. The DON/ADON will audit 1 times weekly x 4 weeks, 1-time monthly x 2 months utilizing the Audit Tool. This audit is to ensure all resident transferred or discharged to the hospital are given the Acute Discharge Notice From and it is sent to the resident representative. The Director of Nursing (DON) will address all concerns identified during the audit to include re-training of nurses. The DON will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Transfer/Discharge/Bed Hold Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of alleged compliance 3/6/23	

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F 625	Continued From page 19 On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the resident to the hospital. The folder did not list that a bed hold policy was to be sent with the resident. On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the business office was to follow up with family the day after the hospital transfer by phone and they are to send a copy of the bed hold policy to the Responsible Party. 2. Resident #442 was admitted to the facility on 08/24/22. Resident #442's medical record revealed he was transferred to the hospital on 11/10/2022. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party. A Significant Change Minimum Data Set (MDS) assessment dated 11/28/2022, indicated Resident #442 was severely cognitively impaired. On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the nurses ' responsibility to send the bed hold policy to the hospital with the resident at time of transfer. On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP). She stated it	F 625		

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was the nurses ' responsibility to send the bed hold
policy to the hospital with the resident at time of transfer.

On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the bed hold policy. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the resident and/or the Responsible Party.

On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family.

On 01/26/23 at 04:43 PM The facility provided a folder that listed the information to be sent with the
resident to the hospital. The folder did not list that

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F 625	Continued From page 21	F 625		

a bed hold policy was to be sent with the resident.

On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the business
office was to follow up with family the day after the hospital transfer by phone and they are to send a
copy of the bed hold policy to the Responsible Party.

3. Resident #80 was admitted to the facility on 11/08/22.

Resident #80's medical record revealed she was transferred to the hospital on 01/11/22 for a nosebleed. There was no documentation that the bed hold policy was given to the resident and/or the Responsible Party.

A Significant Change Minimum Data Set (MDS) assessment dated 01/13/23, indicated Resident #80 was severely cognitively impaired.

On 01/26/23 at 11:36 AM an interview was conducted with Unit Manager #1. She stated it was the
nurses ' responsibility to send the bed hold policy to the hospital with the resident at time of transfer.

On 01/26/23 at 11:37 AM an interview was conducted with Assistant Director of Nursing/Infection
Control Preventionist (ADON/ICP). She stated it was the nurses ' responsibility to send the bed hold
policy to the hospital with the resident at time of transfer.

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On 01/26/23 at 12:23 PM an interview was conducted with Nurse #7. She stated she had worked at the facility through agency since December. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, information on why they are being sent to the emergency room (ER), last labs, and list of medications. She then stated she was not familiar with an envelope at the nurses' station that contained the bed hold policy. She further stated she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would get that information to the resident and/or the Responsible Party.

On 01/26/23 at 12:26 PM an interview was conducted with Nurse #3. She stated she has worked at the facility for a year and half. She also stated the information that she sent to the emergency room with a resident included the face sheet, vital signs, change in condition evaluation form, last labs, nursing notes, and a list of the residents ' medications. She then stated she does not know about an envelope at the nurses' station that contained the bed hold policy for the resident and/or Responsible Party. She preceded to state she thought the Social Worker, Assistant Director of Nursing, or the Unit Manager would send that information to family.

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On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated the

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business
office was to follow up with family the day after the hospital transfer by phone and they are to send a
copy of the bed hold policy to the Responsible Party.

F 677 SS=D — ADL Care Provided for Dependent Residents
CFR(s): 483.24(a)(2) — **F 677** — Completion date: 3/9/23

§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, and resident and staff interview ' s the facility failed to provide showers, nail care, and mouth care to residents who needed extensive and/or were dependent on staff for Activities of Daily Living (ADL). This was for 2 of 2 residents (Resident #79 and #80) reviewed for ADL ' s.

The findings include:

1. Resident #80 was admitted to the facility on 11/08/22 with diagnoses that included hemiplegia (complete paralysis) and hemiparesis (partial weakness) to one side of the body following a cerebral infarction (stroke), contractor (a fixed tightening of muscle, tendons, ligaments, or skin) of left hand, and Parkinson ' s Disease.

Review of Significant Change Minimum Data Set (MDS) assessment, dated 01/13/23, revealed Resident #80 ' s cognition was severely impaired. The resident required extensive assist of one person for bed mobility and toilet use, and she

Provider's Plan of Correction:

F677 ADL Care Provided for Dependent Residents

On 1/25/23, the Certified Nursing Assistant (CNA) gave resident #79 a shower, washed his hair and cleaned and trimmed his nails. Resident #79 was placed on the shower schedule for Sunday and Wednesday each week. On 1/26/23, the CNA gave the resident a bed bath, cleaned the teeth and mouth of resident #80. The resident has passed away.

On 2/14/23, the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) initiated an audit of ADL care of all dependent residents to include nail care, mouth care, washing hair and showers. This audit is to ensure all residents were assisted with ADL care and when refusal of care, its documented in the electronic record. The

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was totally dependent of one person for personal hygiene and bathing. Resident #80 had functional limitations in range of motion (ROM) on one side of upper and lower extremities. Her dental status was coded indicating she had no obvious or likely cavities or broken natural teeth.

Review of Resident #80 ' s care plan dated 11/08/22 with a revision date of 12/10/22 revealed a focus for Activities of Daily Living with the following interventions: Personal Hygiene/Grooming-Provide total care for wash and dry face, skin, nails, hands, and perineum, and Bathing-total dependence with one person assist.

During observation on 01/23/23 at 11:13 AM, Resident #80 was observed lying in bed with mouth open. Tongue, teeth, gums and between teeth and side of mouth with dry brown/yellowish/white substance noted. Substance appears hard on tongue and teeth. Lips appear dry and cracked.

An observation and interview with Nurse #5 were conducted on 01/23/23 at 03:48 PM. Observation of Resident #80 revealed she was lying in bed with mouth open. Tongue, teeth, gums and between teeth and side of mouth with dry brown/yellowish/white substance noted. Substance appears hard on tongue and teeth. Lips appeared soft and shiny. Interview with Nurse #5 was conducted. She stated that resident is a "mouth breather" and keeps her mouth open all the time. She stated she gets mouth care every shift (7am-3pm, 3pm-11pm, and 11pm-7am). Nurse #5 assessed residents ' mouth and stated it normally looks like that because her mouth gets dry from having mouth

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DON/ADON/UM will address all concerns identified during the audit to include assisting dependent residents with ADL care and education of staff. Audit will be completed by 3/6/23.

On 2/14/23, the DON/ADON/UM□s initiated an in-service with all nurses and nursing assistants regarding ADL Care with emphasis on ensuring nails are clean and trimmed per resident preference and mouth care is provided for all dependent residents. In-services will be completed by 3/6/23. After 3/6/23, any nurse or nursing assistant to include agency and contract staff who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and nursing assistants, agency and contract staff will be in-serviced during orientation regarding ADL Care.

The DON/ADON/UM□s will review Point Click Care (PCC) documentation to ensure bath/showers, nail care, and mouth care are being completed as assigned. Resident observation, and checking the shower schedule daily, asking the resident if a shower was received or assessing the resident unable to state shower was given, this will be performed by the DON/ADON/UM and Administrator to include resident #79, (resident #80 is no longer in the facility) weekly x 4 weeks then monthly x 1 month utilizing the ADL Audit Tool and the Shower/Bath Audit Tool. This audit is to ensure all dependent residents were assisted with ADL care and refusals of

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open.

During observation on 01/24/23 at 09:45 AM, Resident #80 was observed in bed. Head of bed elevated, Resident #80 was observed lying in bed with mouth open. Tongue, teeth, gums and between teeth and side of mouth with dry brown/yellowish substance noted. Continues to appear hard on tongue. Lips appear dry and cracked.

During observation and interview with Nursing Assistant (NA)/Medication Aide #9 were conducted on 01/25/23 at 04:15 PM. Resident #80 was observed in bed. Head of bed elevated, mouth open, mucous membranes moist with small amount of yellowish/brown material on it. Teeth with yellowish substance on them. Lips appeared soft and shiny. During interview with NA/Medication Aide #9 she indicated she checks the shower chart prior to going to her assigned area to see who is scheduled a shower during her shift. She stated she includes mouth care in morning care.

During observation on 01/26/23 at 11:20 Resident #80 was observed in bed. Head of bed elevated, mouth open, mucous membranes moist with small amount of yellowish/brown material on it. Teeth slightly improved.

On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated his expectation was for mouth care to be performed every shift and more frequently with a resident that received nothing by mouth and was a mouth breather.

On 01/27/23 at 11:25 AM an interview was

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care documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit. The DON will review the ADL Audit Tool 1 time weekly x 4 weeks then monthly x 2 month to ensure all concerns were addressed.

The DON will forward the results of ADL Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the ADL Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

Date of alleged compliance 3/6/23

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conducted with Nurse #2. She stated she performs mouth care on Resident #80 at least three times during her shift. She also stated she appeared to have a small amount of dried blood between her bottom teeth and bottom lip that she attempted to get off but did not want to hurt her mouth. She further stated the resident needed frequent mouth care due to her mouth breathing. She always keeps her mouth open which dries her mouth out.

Observation of Resident #80 and interview was conducted on 01/27/23 at 11:35 AM with the Director of Nursing (DON). She confirmed Resident #80 ' s tongue and mouth were open, mucous membranes moist with yellowish/brown material on it and her teeth had a yellowish substance on them. She stated mouth care did need to be performed. She also stated it was her expectation that nurses, and Nursing Assistants (NA ' s) perform mouth care on residents every shift. She further stated when a resident received nothing by mouth and was considered a mouth breather, that resident would require more frequent mouth care. Her expectation would be for mouth care to be more preformed more frequent and a mouth lubricant to be administered.

2. Resident #79 was admitted to the facility on 11/14/22 with diagnosis of hemiparesis.

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Review of the admission minimum data set (MDS), dated 11/20/22, revealed Resident #79 to be cognitively intact and require total assistance with bathing, dressing, and transfers.

Review of Resident #79's care plan dated 11/26/22 with a revision date of 1/24/23 revealed a focus for Activities of Daily Living/Personal are with the following interventions: the resident required total care for personal hygiene including nail care and bathing.

During observation and interview on 1/24/23 at 9:13am, Resident #79 was observed lying in bed with fingernails on both hands that were very long, jagged and hair that was matted to his head. Resident #79 stated he had asked the nursing staff (unable to recall names) for assistance with trimming his fingernails and showers.

An interview with Unit Manager #1 was conducted on 1/24/23 at 10:28 AM. She stated the daily shower list was located at the nurses' station in a binder. She also stated that the NAs were to view the list in the AM to see who has showers due for the day. She stated there has been times that some residents did not get their scheduled showers due to the facility being short staffed. She stated they will try to get staff to stay over to complete the task or staff would complete the shower the next day, but it did not always occur. If the resident refuses a shower the NA would tell the nurse, the nurse will ask the resident and if the resident continued to refuse the NA and nurse would document refusal.

A review of the facility shower schedule was completed on 1/25/23 at 9:11am. Resident #79

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F 677	Continued From page 28 was not listed anywhere on this schedule and handwritten note at the bottom stating that Resident #79's room number was missing. During an observation on 1/25/23 at 11:49am Resident # 79's long fingernails and matted hair remained unchanged. An interview was conducted with NA #13 on 01/25/23 at 11:49 AM. He indicated that he was the NA assigned to resident #79 and had completed am care this morning. NA #13 was not aware Resident #79's fingernails were long or that he needed a shower. He indicated that he has only worked at this facility for 2 days but that he checks the shower book to know which of his residents are on the schedule for a shower and nails are trimmed as needed. He reviewed the shower book and stated that he did not see Resident #79 assigned to a shower day. A review of Resident #79's Activities of Daily Living documentation from November 2022 to present revealed no documentation that showers had been provided and no refusals noted. A review of the grievance logs from November 2022 to present revealed a grievance submitted by Resident #79 on 12/27/22 with a complaint that he had not gotten a shower. The resolution was that staff were to be educated that about making sure residents are given showers on schedule. An interview was conducted with the Administrator on 01/27/23 at 10:10 AM. He revealed since he has been the administrator at this facility, he has not experienced any staffing problems that would interfere with staff's ability to	F 677		

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F 677	Continued From page 29 perform their duties to provide resident care. He stated he has not seen any indication of decreased staffing and administrative nurses have not been pulled to work in a NA role. He further stated staff say that they are short to relieve themselves of the responsibility to provide showers. The administrator said his expectation was for the facility to honor the resident's preference for shower or bath by providing person-centered care.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 2 residents reviewed for pressure ulcers (Resident #80). The findings include:	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer On 1/25/23 The Treatment Nurse adjusted the air mattress settings for Resident #80 to the ordered range of weight 90-150 lbs, Medium Firm with 10-minute cycle time, alternate.	3/6/23

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F 686	Continued From page 30 Resident #80 was admitted to the facility on 11/08/22 with diagnoses that included cerebral infarction (stroke) and a stage IV coccyx pressure ulcer. Resident #80's active physician orders included an order dated 12/18/22 for an alternating pressure air mattress to the bed. Nursing to check setting every day and night shift. Settings: Weight 90-150lbs, Medium firm, 10 minutes cycle time, Alternate. Review of Significant Change Minimum Data Set (MDS) assessment, dated 01/13/23, revealed Resident #80 ' s cognition was severely impaired, one stage 4 pressure ulcer, one Deep Tissue Injury (DTI), and a pressure reducing device to the bed. Resident #80's weight on 1/2/2023 was 133.0 pounds (lbs). Review of Resident #80 ' s care plan dated 11/08/22, last reviewed 12/16/22, included a focus area that read; admitted with pressure ulcers, and at risk for skin breakdown or development of further pressure ulcers related to high risk for pressure ulcer. One of the interventions included to place resident on pressure relieving products such as pressure relieving mattresses-settings at 90-150 pounds (lbs), medium firm and at 10 minutes cycle, and chair cushions as appropriate. A review of Resident #80's medical record revealed ongoing wound care was provided to a coccyx pressure ulcer since 11/08/22 and to a Deep Tissue Injury (DTI) to the right outer arch of foot since 12/14/22.	F 686	On 2/14/23 The Corporate Clinical Director reviewed all residents' orders on air mattress and updated the order to require the nurse/treatment nurse to sign off on the EMAR the mattress was at the correct settings. On 2/15/23, The Director of Nursing/Assistant Director of Nursing/Unit Manager the initiated an in-service with all nurses and treatment nurses on air mattress setting, and documentation on the EMAR. In-services will be completed by 3/6/23. After 3/6/23, any nurses to include agency and contract staff who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, agency and contract staff will be in-serviced during orientation regarding air mattress settings and documentation on the EMAR. On 2/20/23 DON/ADON/UM's will audit all residents with air mattress to ensure the mattress is set at the correct setting 1 x's weekly x 4 weeks, then 1-time monthly x 2 months. The DON/ADON and UM will address all concerns identified during the audit to include additional education of nurse/treatment nurse. The DON will forward the results of ADL Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Audit Tool to determine trends and / or issues that may need	

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Review of the operational manual for the alternation air/low loss mattress indicated the pressure level of the air mattress was according to the health care professional recommendations.

The January 2023 Medication Administration Record (MAR) revealed nursing staff had been documenting the alternating pressure air mattress was functioning properly.

An observation occurred of Resident #80 on 01/23/23 at 11:14 AM and at 12:48 PM. She was lying in bed with her eyes closed. The alternating pressure reducing air mattress was set on "firm" and to cycle every 15 minutes.

An observation occurred of Resident #80 on 01/23/23 at 03:40 PM. She was lying in bed with her eyes closed. The alternating pressure reducing air mattress was set on "firm" and to cycle
every 15 minutes.

An observation and interview were conducted on 01/23/23 at 03:50 PM. She was lying in bed with her eyes open. The alternating pressure reducing air mattress was set on "firm" and to cycle every 15 minutes. An interview was conducted with Nurse #5. She confirmed the air mattress was set on "firm" and was cycling every 15 minutes and the nurses are to check the air pressure settings and cycling time every shift. She stated she would have to look at the order to clarify the ordered settings.

On 01/25/23 at 10:10 AM an interview was conducted with the Director of Nursing (DON). She
stated the facility does not have a wound Nurse

further interventions put into place and to determine the need for further and / or frequency of monitoring.

Date of alleged compliance 3/6/23

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F 686	Continued From page 32 Practitioner (NP) or a wound physician at this time. She also stated residents were treated by the facility Wound Care Nurse Monday through Friday. She further stated she expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine. On 01/25/23 at 10:10 AM an interview was conducted with the Wound Nurse. She stated the air mattress settings were checked by the nurses during rounds and she checked them when she did wound care. She indicated she had not preformed wound care yet therefore she had not checked the settings of the air mattress. On 01/27/23 at 11:13 AM an interview was conducted with the Administrator. He stated his expectation was for the air mattress to be set according to what the order reads	F 686		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an	F 729		3/6/23

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F 729	Continued From page 33 individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Nurse Aide Registry forms and staff interviews the facility failed to verify with the North Carolina (NC) Nurse Aide Registry a Nursing Assistant's (NA#12) certification for 1 of 3 employees reviewed (NA #12). The findings included: NA #12 was hired by the facility on 7/20/2010 to work with residents in need of care and treatment. A review of NA #12's personal file indicated that NA #12's Nurse Aide Certification had expired on 11/20/2022. A review of the staffing schedule sheet from December 23, 2022, to January 23, 2023, revealed NA #12 had worked during the	F 729	F729 Nurse Aide Registry Verification, Retraining On 1/26/23 all certified nursing assistance (CNA) currently employed with the facility have had their employee files audited by the Administrator and Director of Nursing (DON) for current certification status to ensure that their certification is not expired and is currently active. The Administrator/ DON will address all concerns identified during the audit. On 1/26/23 an in-service conducted by the Administrator was completed with the facility receptionist and payroll manager on completing monthly verification of the facility staff nurse aide and agency nurse	

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F 729	Continued From page 34 timeframe of the schedules reviewed. On 01/26/23 at 4:00 PM an interview was conducted with the Senior Administrator, and she presented the NC Nurse Aide Registry form dated 01/26/23 and it verified NA #12's Nurse Aide Certification had expired on 11/20/22. The Senior Administrator indicated that the facility contacted NC Nurse Aide Registry and was informed that NA#12's certification had expired. The Senior Administrator indicated that on 01/26/23, the facility had contacted NA #12 and informed her she would be unable to return to work until her certification with the Nurse Aide Registry was current. On 01/27/23 at 9:05AM during an interview with the receptionist she verified on 01/26/23 she was assigned the task to monitor and check the Nurse Aide Registry to ensure the current NA's working had current certifications on file. The Receptionist stated she knew NA #12 had worked for the facility for years, but she had no knowledge of NA #12's certification information prior to being assigned the task to verify the NA's certification status.	F 729	aide certifications. On 01/26/23 an in-service was completed by the Administrator with the payroll manager on reporting current licensure status, renewals and certification issues during the Cardinal IDT meeting. On 01/26/22 All certified nursing assistants and nurses have been in-serviced by the DON on the responsibility of maintaining a current certification/license to remain in professional practice as outlined by their governing bodies. The Receptionist will monitor and validate all certifications/license. The Administrator will review the Employee Certification/Licensure Audit Tool 1 time weekly x 4 weeks and 1 time monthly x 2 months for completion and confirmation that all licensed nurses and certified nurse assistants possess an active license. The Administrator will forward the results of Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of alleged compliance 3/6/23	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		3/6/23

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F 760	Continued From page 35 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, psychiatric nurse practitioner and staff interviews, the facility failed to administer duloxetine hydrochloride (an antidepressant medication) for eleven days as ordered by the psychiatric nurse practitioner for 1 of 5 sampled residents (Resident# 27) reviewed for unnecessary drugs. Findings included: Resident #27 was admitted to the facility on 11/14/17 with diagnoses which included: major depressive disorder, disorganized schizophrenia, and bipolar disorder. The quarterly assessment dated 12/3/22 indicated Resident #27 was severely, cognitively impaired; had no behaviors; and, received antipsychotic and antidepressant medications. The care plan dated 12/17/22 revealed Resident #27's use of psychotropic drugs (antipsychotic, antidepressant) with the potential for side effects of cardiac, neuromuscular, gastrointestinal systems related to his psychological diagnoses. Interventions included: evaluate effectiveness and side effects of medications for possible reduction of psychotropic drugs; and monitor his mood/behaviors (anxiety, agitation, hallucinations, depression) with documentation per facility policy. The Psychiatry Follow Up Note dated 1/11/23 recommended Resident #27 receive a GDR (gradual dose reduction) of duloxetine	F 760	F760 Residents are Free of Significant Med Errors On 1/26/23 the medication order for Duloxetine Hydrochloride was corrected and resident #27 began receiving the correct medication. On 1/27/23, the Interdisciplinary Team (IDT) began auditing all residents' medication orders during the IDT meeting to ensure all medication orders are transcribed correctly and the residents are receiving the correct medication. On 2/17/23 The Director of Nursing (DON)/Assistant Director of Nursing (ADON) initiated an in-service with all nurses, agency and contract staff on medication transcription, and documentation on the EMAR. In-services will be completed by 2/28/23. After 2/28/23, any nurses to include agency and contract staff who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, agency and contract staff will be in-serviced during orientation regarding medication transcriptions and documentation on the EMAR. The DON/ADON/Unit Manager will audit all residents' medication orders to ensure all medication orders are transcribed	

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F 760	Continued From page 36 hydrochloride from 60mg (milligrams) per day to 30mg per day; and staff to monitor the resident's sleep, appetite, weight, mood and behavior. Review of the clinical records revealed an order was written on 1/14/23 by the psychiatric nurse practitioner for Resident #27 to receive 30mg duloxetine hydrochloride capsule delayed release particles, everyday. The review of the January 2023's medication administration record (MAR) indicated duloxetine hydrochloride 60mg was discontinued and last administered to Resident #27 on 1/14/23. The MAR also revealed Resident #27 was to begin receiving duloxetine hydrochloride 30mg per day on 1/15/23 "pending confirmation" and to discontinue the medication on 1/16/23. The January 2023 MAR indicated Resident #27 did not receive any dosage of duloxetine hydrochloride from 1/15/23 through 1/25/23 (eleven days). On 1/23/23 at 4:01 p.m., Resident #27 was observed sitting quietly in his room feeding himself a sandwich and drinking water while watching a television show. The resident was alert and verbally pleasant. Resident #27 showed no disruptive behaviors and voice or showed any signs of pain. During a telephone interview on 1/27/23 at 9:56 a.m., the Psychiatric Nurse Practitioner stated that she had been working closely with Resident #27's family with tapering his medications. She revealed she wrote an order for Resident #27's 60mg duloxetine hydrochloride to be changed to 30mg duloxetine hydrochloride on 1/14/23. She	F 760	correctly and the residents are receiving the correct medication 1 time weekly as an ongoing audit during the Cardinal Interdisciplinary Team meeting. The DON/ADON and UM will address all concerns identified during the audit to include additional education of nurse/treatment nurse. The Director of Nursing (DON) will forward the results of IDT meeting Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review IDT meeting Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Date of alleged compliance 3/6/23	

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F 760	Continued From page 37 indicated that during an onsite visit on 1/25/23 she discovered the medication had been discontinued. The Psychiatric Nurse Practitioner stated she reported the discrepancy to the Director of Nursing. She stated that she rewrote the order for the 30 mg duloxetine hydrochloride on 1/25/23 after assessing the Resident #27. She concluded the 11 days without the medication in his system did not appear to affect Resident #27 in a negative way. On 1/27/23 at 10:35 a.m., the Director of Nursing (DON) confirmed the Psychiatric Nurse Practitioner had informed her someone had discontinued Resident #27's duloxetine hydrochloride order for 30mg per day on 1/15/23. An interview with Unit Manager #1 on 1/27/23 at 1:00 p.m. revealed she created the Psychiatric Nurse Practitioner's telephone order to discontinue Resident #27's 30mg duloxetine hydrochloride on 1/14/23 and she confirmed the order by reviewing the pending orders in the electronic MAR.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly 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	F 812		3/6/23

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F 812	Continued From page 38 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure dishware was stored and stacked clean and dry; The facility also failed to ensure the food items not provided by the facility were dated and labeled with the residents' names, dates and room numbers when stored in the snack/nourishment refrigerators; and food items served to but refused by residents were not stored in 1 of 3 residents' nourishment rooms. These practices had the potential to affect food served to residents. Findings included: 1. On 1/25/23 at 11:40 a.m., during an observation of the meal service tray line preparation, 44-food stained and/or greasy plates were stacked in the plate warmer located ready for use next to steamtable. There were also 3-sectioned/divided plates with dried food stains, one of which was also chipped stacked on the meal service trayline. There were 4-large muffin tins with dried food debris and greasy stains and 1-large (6"deep) steamtable pan with dried food stains stacked on the storage rack next to clean and dry pots and pans. The Dietary Consultant removed the identified soiled dishware and rewashed the plates and put the soiled pans in	F 812	F 812 FOOD PROCUREMENT, STORE/PREPARE/SERVE—SANITARY (F) On 2/15/23, The Certified Dietary Manager (CDM) will educate the dietary department on sanitation including ensuring the items that have been cleaned are inspected for cleanliness and proper condition prior to storing them for use. On 2/15/23, Nursing and dietary staff will be educated by the CDM and/or DON that food items not provided by the facility are to be dated and labeled with residents' names, dates and room numbers when stored in the snack/nourishment refrigerators; and food items provided by the facility that are served to resident, but are refused, will be discarded and not placed in the nourishment rooms. On 2/15/23 The CDM and/or Nursing Home Administrator (NHA) will monitor 2x/week x4 weeks and then weekly x1 month to ensure items are properly labeled in the nourishment room refrigerators and nourishment rooms and	

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F 812	Continued From page 39 the 3-compartment sink. 2. On 1/25/23 at 12:15 p.m., accompanied by the Assistant Dietary Manager, the 100/200 hall nourishment room was observed. The refrigerator contained one (20 oz.) resealed bottle of soda and one unopened 8 ounce container of organic whole milk that were not labeled with a resident's name and date of storage. Also, stored in the top cabinet above the sink in the nourishment were 5(.75oz) sealed single serve dry cereals. On 1/25/23 at 12:20 p.m., the Assistant Dietary Manager revealed the container of organic milk in the refrigerator was not purchased by the facility's dietary services. He also stated that the dietary department did not store cereals in the nourishment rooms, cereals were only served on residents' meal trays during breakfast. He discarded the container of organic milk and the 5-containers of cereals into the trash bin.	F 812	that inappropriate food items are not stored The CDM and/or NHA will monitor 2x/week x4 weeks and then weekly x1 month to ensure proper cleaning/sanitation of washed items and no chips in wares to be used for service. Any issues identified will be addressed at the time of discovery. in the nourishment room/refrigerator. Any issues identified will be addressed at the time of discovery. The CDM/NHA will forward the results of Dietary Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Dietary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The allegation of compliance date for all action items is 3/6/23	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interviews, the facility failed to ensure the area surrounding 1 of 1 trash compactor remained free from standing water and refuse. These unsanitary practices had the potential to affect the environment of the residents.	F 814	F 814 DISPOSE GARBAGE AND REFUSE PROPERLY The Nursing Home Administrator will ensure that the area surrounding the trash compactor remains free from standing	3/6/23

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F 814	Continued From page 40 Findings included: During an observation, accompanied by the Dietary Manager (DM) on 1/23/23 at 10:05 a.m., there was a mattress with puddles of water floating on top, lying on the ground next to the trash compactor. Also, there was a large pool of standing water and leaves beneath and surrounding the trash compactor. On 1/23/23 at 10:06 a.m., the DM stated the leaves should have been raked from beneath the trash compactor so the rainwater could drain. The DM indicated she had no knowledge why a mattress was placed on the ground next to the compactor. During an interview on 1/27/23 at 11:10 a.m., the Administrator stated that his expectation was for the facility's environmental and dietary staff to check and ensure the trash compactor and the surrounding area were free from debris when they disposed of trash from the facility.	F 814	water and refuse. On 2/15/23, The CDM and/or NHA will educate the dietary department and environmental managers regarding ensuring proper drain flow on the exterior of the facility and keeping the trash compactor area free from refuse. On 2/15/23, The CDM and/or NHA will initiate an audit of the exterior drains and trash areas 3x/week x4 weeks and then weekly x1 month to ensure no standing water and no trash outside of the trash receptacle. Any issues will be addressed at the time of discovery. The CDM/NHA will forward the results of Garbage and Refuse Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Garbage and Refuse Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The allegation of compliance date for all action items is 3/6/23	
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all	F 847		3/6/23

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F 847	Continued From page 41 of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not	F 847		

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F 847	Continued From page 42 limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident representative interviews and staff interviews, the facility failed to explain to resident representatives that the binding arbitration agreement was not a condition of admission for 3 of 3 residents who entered into an Arbitration Agreement with the facility. (Resident #89, Resident #492, and Resident #493). The findings included: The Resident and Facility Arbitration Agreement, last revised on 08/01/22, included a statement that executing this agreement is not a precondition of admission. a. Resident #89 was readmitted to the facility on 11/17/22. A review of Resident #89's admission assessment dated 12/4/22 indicated that Resident #89 had severe cognitive impairment. During an interview with the resident representative on 1/27/23 at 1:20pm she indicated that the admission coordinator explained the process of arbitration and that this needed to be signed to admit Resident #89. b. Resident #492 was admitted to the facility on 1/16/23 with a diagnosis of dementia. During an interview with the resident representative on 1/27/23 at 10:29am she indicated that she could not recall who met with her to sign the admission paperwork, but it was	F 847	F847 Entering into Binding Arbitration Agreements On 1/30/23, For residents #89, #492, #493, the Regional Director of Business Development informed the Admissions Director on the policy and procedure for Binding Arbitration Agreement. On 2/17/23 The Regional Director of Business Development will in-service the back-up Admission person. The facility was not using the correct form. On 1/30/23 the Admissions Director updated the Binding Arbitration Agreements. The Regional Director of Business Development will in-service the Admissions Director/ Back-up Admission person on the Admission policy and procedure process every 6 months x 2 to ensure any updates to the admission process are communicated. The Admissions Director/Back-up Admission person will review weekly x 4 weeks the admission packets to include the Binding Arbitration Agreement to ensure the correct form was completed, education was provided resident and resident representative that signing the	

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F 847	Continued From page 43 explained as a requirement of admission. c. Resident #493 was admitted to the facility on 1/14/23 with a diagnosis of dementia. During an interview with the resident representative on 1/27/23 at 10:27am she revealed that she met with Medical Records Staff member filling in for admission. The arbitration process was explained and that it was required for admission. A telephone interview was conducted with the Admissions Coordinator on 1/27/23 at 9:58am. She indicated that she is responsible for completing the admission paperwork which included the arbitration agreements, with residents or resident representatives but that other departments fill in when she is not available. She further revealed that she understood the arbitration agreement to be required for admission and was not aware that the agreement stated it was not a precondition of admission. An interview was conducted with the facility administrator on 1/27/23 at 11:05am. He indicated that he is an interim administrator but that it is his expectation for the arbitration agreement to explained to the person and ensure their understanding before signing the agreement and it is not a requirement for admission.	F 847	form was not a condition for admission. The Admissions Director will forward the results of Arbitration Agreement Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review Arbitration Agreement Audit to determine trends and or issues that may need further interventions put into place and to determine the need for further and /or frequency of monitoring. Date of alleged compliance 3/6/23	
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	F 867		3/9/23

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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 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

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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 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

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F 867	Continued From page 46 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 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, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint surveys dated 2/4/20 and 1/18/22 and for complaint survey on 8/18/21 in order to achieve and sustain compliance. This was for recited deficiencies on a recertification survey on 1/27/23. The deficiencies were in the area of	F 867	F867 QAPI/QAA Improvement Activities On 1/25/23, the Certified Nursing Assistant (CNA) gave resident #79 a shower, washed his hair and cleaned and trimmed his nails. On 1/26/23, the CNA gave the resident a bed bath and cleaned the teeth and mouth of resident #80. Resident #80 has passed away. On 2/13/23, the Director of Nursing initiated	

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Continued From page 47

notice requirements before transfer/ discharge, Activity of Daily Living (ADL) care provided for dependent residents and residents free of significant medication errors. The continued failure during four federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program.

The findings included:

This tag is cross-referenced to:

1. F623 -Based on record review and staff interviews, the facility failed to provide the resident and/or Responsible Party (RP) written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization (Residents #342, #442 and #80).

During the previous recertification and complaint survey on 2/4/20, the facility failed to provide written notification to the resident, resident's representative, and the ombudsman when a resident was transferred or discharged from the facility. This was evident for 3 of 4 residents reviewed for hospitalization and discharge.

2. F677 - Based on observations, record review, and resident and staff interview ' s the facility failed to provide showers, nail care, and mouth care to residents who needed extensive and/or were dependent on staff for Activities of Daily Living (ADL). This was for 2 of 2 residents (Resident #79 and #80) reviewed for ADL' s.

During the previous recertification and complaint survey on 1/18/22, the facility failed to provide a haircut for 1 of 3 activity of daily living dependent residents reviewed.

F 867

an audit of resident #342, #442 and #80 discharged to determine if the notice of Bed Hold Policy was completed and given to the resident and/or discussed with the resident representative.

On 2/14/23, the DON/ADON/UM initiated an audit of ADL care of all dependent residents to include nail care, mouth care, washing hair and showers. This audit is to ensure all residents were assisted with ADL care to include but not limited to nail care per resident preference when indicated and/or refusal of care documented in the electronic record. On 2/14/23, the Corporate Clinical Director and Social Worker initiated an audit of all residents discharged in the last 30 days to determine if the Bed Hold Policy and Acute Transfer notice was completed and given to the resident and sent to the resident representative. The Director of Nursing (DON) and/or Assistant Director (ADON) of Nursing will address all concerns identified through the audits.

On 2/13/23, the DON/ADON/UM□s initiated an in-service with all nurses and nursing assistants regarding ADL Care with emphasis on ensuring nails are clean and trimmed per resident preference and mouth care is provided for all dependent residents. On 2/13/23 The DON/ADON in-serviced the nurses to include agency and contract staff on the Bed Hold Policy and Acute Transfer notice is to be completed when the resident is transferred to the hospital for an acute issue. The form must be given to the

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F 867	Continued From page 48 3. F760 - Based on observation, record reviews, psychiatric nurse practitioner and staff interviews, the facility failed to administer duloxetine hydrochloride (an antidepressant medication) for eleven days as ordered by the psychiatric nurse practitioner for 1 of 5 sampled residents (Resident# 27) reviewed for unnecessary drugs. During the previous complaint survey on 8/18/21, the facility failed to send medication with a resident who left the facility for the weekend including medications for hypertension and pain management. This occurred for 1 of 3 residents reviewed for medication error. The administrator was unavailable for the Quality Assurance interview. An interview with the Mobile Administrator assisting in the survey was conducted on 1/27/23 at 1:49 PM. The Mobile Administrator stated the Quality Assurance (QA) committee does 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System change and addition task would put in place as needed to resolve the issue. The Mobile Administrator further stated that if there were repeated deficiencies that were identified then the area of concern would become a focus area. The old plan would be revisited and analyzed to see where the failures, and where the breakdown happened. The root cause would be revisited and new interventions, monitoring tools would be put in place. Audit / education would be completed as needed. The team would continuously monitor until the deficient area concerns have been resolved.	F 867	resident and discussed with the resident representative when the resident is transferred to an acute care hospital, the floor nurse will be responsible for giving the resident the bed hold and Business Office Manager will discuss with the family. The in-service will be completed by 3/6//23. After 3/6/23, any nurses, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding the Bed Hold Policy and Acute Transfer notice. After 3/6/23, any nurse or nursing assistant to include agency and contract staff who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and nursing assistants, agency and contract staff will be in-serviced during orientation regarding ADL Care, Bed Hold and Acute Transfer. The DON/ADON/UM□s will review Point Click Care (PCC) documentation to ensure bath/showers, nail care, and mouth care are being completed as assigned. Resident observation will be performed by the DON/ADON/UM and Administrator to include resident #79, (resident #80 is no longer in the facility) weekly x 4 weeks then monthly x 1 month utilizing the Audit Tool. This audit is to ensure all residents were assisted with ADL care to include but not limited to nail care, shower/bath and mouth care per	

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F 867	Continued From page 49	F 867	resident preference when indicated and/or refusal of care documented in the electronic record. The DON/ADON/UM will address all concerns identified during the audit. The Director of Nursing will review the ADL Audit Tool 5 times weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON/ADON will audit 1 times weekly x 4 weeks, 1-time monthly x 2 months utilizing the Transfer/Discharge/Bed Hold Audit Tool. This audit is to ensure all resident transferred or discharged to the hospital are given the Acute Discharge Notice From and it is sent to the resident representative. The DON will address all concerns identified during the audit to include re-training of nurses. On 2/16/23 The Director of Nursing (DON)/Assistant Director of Nursing (ADON) initiated an in-service with all nurses, agency and contract staff on medication transcription, and documentation on the EMAR. In-services will be completed by 2/28/23. After 2/28/23, any nurses to include agency and contract staff who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, agency and contract staff will be in-serviced during orientation regarding medication transcriptions and documentation on the EMAR. The DON/ADON/Unit Manager will audit all resident's medication orders to ensure all medication orders are transcribed	

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F 867	Continued From page 50	F 867	correctly and the residents are receiving the correct medication 1 time weekly as an ongoing audit during the Cardinal Interdisciplinary Team meeting. The DON/ADON and UM will address all concerns identified during the audit to include additional education of nurse/treatment nurse. The Director of Nursing (DON) will forward the results of IDT meeting Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review IDT meeting Audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Facility Consultant/Corporate Clinical Director will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings, to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes, and the Performance Improvement Plans once a month for 2 months. The Administrator will hold monthly Quality Assurance Performance Improvement Committee (QAPI) meetings with the QAPI committee. The meeting agenda will include review of all Performance Improvement Plans (PIP) to include the PIP for ADL□s Performance, Bed Hold Policy and Acute Transfer	

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F 867	Continued From page 51	F 867	notice. The Audit Tools will be reviewed monthly to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 3/6/23	
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 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.	F 883		3/6/23

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F 883	Continued From page 52 §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 staff interviews and record review, the facility failed to offer a pneumococcal (pneumonia) vaccine for 1 of 5 residents (Resident #69) reviewed for immunizations. Findings included: Resident #69 was admitted to the facility on 08/02/21. Review of the Quarterly Minimum Data Set (MDS) dated 11/03/22 revealed Resident #69 was	F 883	F883 Influenza and Pneumococcal Immunizations On 1/26/23 and 2/15/23 Resident # 69 refused the Pneumococcal Immunization. On 2/20/23, an audit of all residents who have consented to the Influenza and Pneumococcal Immunizations was initiated by the ADON/UM to ensure all residents requesting the immunizations have received them. The audit will be	

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F 883	Continued From page 53 severely cognitively impaired. Further review revealed the MDS coded the pneumonia vaccine as not up to date and that the pneumonia vaccine was not offered. Review of the policy titled Infection Control Guidelines, which had a revision date of 03/10/20, read in part; There are two pneumococcal (Pneumonia) vaccines recommended for adults. These vaccines are the pneumococcal conjugate 13 vaccine (PCV 13) and the pneumococcal polysaccharide 23 vaccine (PPSV23). These vaccine recommendations are established by the Centers for Disease and Control (CDC) and the Advisory Committee on Immunization Practices (ACIP). Pneumonia vaccines are given on admission unless contraindicated was noted on the consent/release form. A review of Resident #69's medical record revealed there was no documentation to indicate whether the resident received the pneumococcal vaccine. Consent signed by family on 6/21/22 was noted in Resident #69 ' s electronic medical record. No refusal form or nursing note revealing refusal was on file. An interview was conducted on 01/26/23 at 10:02 AM with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). She stated if a resident refused a vaccine she would add "refused" under immunizations in Point Click Care (PCC). She stated if a resident refused a vaccine, it should be documented in the nursing notes and a refusal form signed. An interview was conducted on 01/27/23 at 11:35 AM with the Director of Nursing (DON). She	F 883	completed by 2/24/23. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. On 2/15/23, the Regional Nurse Consultant initiated an in-service with the Director of Nursing/Assistant Director of Nursing(IP nurse)/Unit Managers on the policy and procedure for offering residents the Pneumococcal Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization. On 2/20/23 The Director of Nursing/Assistant Director of Nursing/Unit Manager will audit all new admissions to ensure the resident and resident representative have been education on immunizations and offered to receive immunizations on admission. At admission the DON/ADON/UM will provide education to the resident and resident representative on Pneumococcal immunizations and offer to provide the immunization. Immunizations for Pneumonia will be audited weekly x 4 weeks and then 1 time monthly x 2 months. The DON/ADON and UM will address all concerns identified during the audit to include additional education of nurses to include agency and contract staff. The Assistant Director of Nursing/Unit Managers will forward the results of Audit	

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F 883	Continued From page 54 stated if a resident originally consented/refused to receive a vaccine but later refused/consulted, she expected nursing to document the consent/refusal in the nursing notes. She also stated a new consent/refusal form should be filled out and filled in chart. She further stated the administration of a vaccine should be documented on the Medication Administration Record (MAR).	F 883	to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review Immunization Audit to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 3/6/23	
F 887 SS=D	COVID-19 Immunization 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	F 887		3/9/23

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F 887	Continued From page 55 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 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 review and interviews with staff the facility failed to maintain a resident's record of refusal or if contraindicated for the vaccine for COVID-19 for 2 of 5 residents reviewed for COVID-19 vaccination status (Resident #44 and #242).	F 887	F877 COVID-19 Immunization On 1/25/23 Resident #44 and #242 were offered and refused the COVID-19 Immunization, it was documentated on the immunizations record on the resident chart in Point Click Care.	

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F 887	Continued From page 56 Findings included: Review of the policy, Principle Covid-19 Guidelines, last revised 10/2022, revealed in part, that residents are encouraged to remain up to date with all recommended COVID-19 vaccinations. 1. Resident #44 was admitted to the facility on 04/14/16. Review of Resident #44's medical records revealed no documentation that the COVID-19 vaccine was contraindicated, administered, or refused. An interview was conducted on 01/26/23 at 10:02 AM with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). She stated if a resident refused a vaccine she would add "refused" under immunizations in the electronic record. She also stated that the facility does not currently have a consent/refusal form for the COVID-19 vaccine. An interview was conducted on 01/27/23 at 11:35 AM with the Director of Nursing (DON). She stated a new consent/refusal form should be filled out and filed in the resident ' s chart. She also stated the administration of a vaccine should be documented on the Medication Administration Record (MAR). 2. Resident #242 was admitted to the facility on 07/08/20. Review of Resident #242's medical records revealed no documentation the COVID-19 vaccine was contraindicated, administered, or	F 887	On 2/15/23, ADON/UM will audit all residents to ensure they have been offered the COVID-19 immunizations, if refused it will be documented as refusal in Point Click Care (PCC) Immunizations section. The audit will be completed by 2/17/23. The Assistant Director of Nursing/Unit Managers will address all concerns identified during the audit. Signed Consent Forms were placed in the resident chart and the immunizations were recorded in the resident chart in Point Click Care. On 2/15/23, the Regional Nurse Consultant initiated an in-service with the Director of Nursing/Assistant Director of Nursing(IP nurse)/Unit Managers on the policy and procedure for offering residents the COVID-19 immunization, documenting consent or refusal of the immunizations under the immunizations tab in the resident chart and the resident and resident representative have received education regarding the benefits and potential side effects of the immunization. On 2/15/23 The Director of Nursing/Assistant Director of Nursing/Unit Manager will audit all residents□ charts to ensure the COVID-19 immunization has been offered and documenting consent or refusal of the immunizations under the immunizations tab in the resident chart. Immunizations will be audited 1 time weekly x 4 weeks and then 1 time monthly x 2 months. The ADON/UM will address all concerns identified during the audit to	

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F 887	Continued From page 57 refused. An interview was conducted on 01/26/23 at 10:02 AM with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). She stated if a resident refused a vaccine she would add "refused" under immunizations in the electronic record. She also stated that the facility does not currently have a consent/refusal form for the COVID-19 vaccine. An interview was conducted on 01/27/23 at 11:35 AM with the Director of Nursing (DON). She stated a consent/refusal form should be filled out and filed in the resident ' s chart. She also stated the administration of a vaccine should be documented on the Medication Administration Record (MAR).	F 887	include additional education of nurses to include agency and contract staff. The Assistant Director of Nursing/Unit Managers will forward the results of Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review Immunization Audit to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 3/6/23	