STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/06/23 through 03/09/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NNC011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/06/23 through 03/09/23. Event ID# NNC011. The following intakes were investigated NC00198454, NC00197376 and NC00187193. 3 of the 3 complaint allegation did not result in deficiencies.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge 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.	F 623		4/14/23

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

Electronically Signed | 03/24/2023

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F 623	Continued From page 1	F 623		

(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, 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

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F 623	Continued From page 2 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. §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 reviews and interviews with staff, the facility failed to provide the resident	F 623	The statements made on this plan of correction are not an admission to and do	

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F 623	Continued From page 3	F 623		

and/or Responsible Party (RP) written notification of the reason for a hospital transfer for 2 of 3 residents reviewed for hospitalization (Residents #54 and #17).

The findings included:

1. Resident #54 was admitted to the facility on 11/3/20.

A quarterly Minimum Data Set (MDS) assessment dated 2/3/23 indicated Resident #54 was cognitively intact.

Resident #54's medical record revealed she was transferred to the hospital on 2/26/23 for altered mental status and was readmitted to the facility on 3/4/23. There was no documentation that written notice of transfer was provided to the resident and/or RP for the reason of the transfer.

The Social Worker (SW) was interviewed on 3/7/23 at 10:55 AM and stated she was not responsible for notifying the resident or RP when a resident was discharged to the hospital.

On 3/7/23 at 10:56 AM, the Admissions staff member was interviewed and stated that she began employment at the facility 2 weeks ago. She was responsible for notifying the resident or RP when a resident was discharged to the hospital. She called the RP, discussed the bed hold policy and requested the RP to come to the facility to sign the bed hold form. She then provided the RP a copy of the form with the reason and date the resident was discharged to the hospital.

An interview occurred with the Administrator on

not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F623 The facility failed to provide the resident and or responsible party (RP) with written notification for a transfer to the hospital for 2 of 3 residents.
Corrective action for resident(s) affected by the alleged deficient practice
On 3/ 10 /2023 written notification of the reason for hospital transfer was mailed to the responsible party for resident # 54 and # 17 by the social service director.
Corrective action for residents with the potential to be affected by the deficient practice
On 3/ 10 /2023, the Administrator and Social Service Director completed a 100 % audit of discharges for the last 14 days to ensure that there were no discharges that didn't have a written notification sent or provided to the resident and/or responsible party. The results included: 15 discharges.
On 3/ 10 /2023 written notification of the reason for transfer to the hospital was sent to all above identified responsible parties and or residents by the 3/14/23
Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 3/ 10 /23, the Regional Operations Manager provided Notice Requirements

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F 623	Continued From page 4 3/9/23 at 9:10 AM. She stated that the Admissions staff member was responsible for notifying the resident or RP when a resident was discharged to the hospital. She added that the Admissions staff member called the RP, explained the bed hold policy and requested the RP come to the facility and to sign the bed hold form. The form included the reason and date of hospital discharge. After the bed hold form was signed, a copy was provided to the RP or resident. The Administrator further explained when Resident #54 was discharged to the hospital, the previous Admissions staff member, who no longer worked at the facility, did not have the bed hold form completed or signed by the resident/RP. 2. Resident # 17 was originally admitted to the facility on 1/23/12 and was readmitted on 2/13/23 with multiple diagnoses including cerebrovascular accident (CVA) with aphasia and dysphasia. The quarterly Minimum Data Set (MDS) assessment dated 2/13/23 indicated that Resident #17 had severe cognitive impairment. A nursing note dated 1/29/23 at 3:34 AM revealed that Resident #17 had a medium stool with small blood clots present in brief. The note indicated that the resident was stable with no complaints of abdominal pain and his vital signs were within normal limits. The Physician Assistant (PA) was notified and ordered to monitor the resident and to call back if the vital signs or the resident status worsen. A nursing note dated 1/29/23 at 2:12 PM, Resident #17 was seen by the PA and ordered to send the resident to the emergency room for evaluation and treatment.	F 623	before Transfer education to the Administrator, Business Office Manager, and Social Services Director. All training was completed by 3/ 14 /23 Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing F-tag 623 Notice Requirements before Transfer monitoring QA tool. Observation will include review of all transfers/discharges in the daily stand up meeting (Monday-Friday) to ensure that written notification process to the resident/responsible party is in compliance. Audits will be done weekly x 4 and then monthly x 3 or until resolved. The ongoing auditing program will be reviewed at the monthly Quality Assurance Meeting until deemed as no longer necessary for compliance. Date of compliance: 4/14/2023.	

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F 623	Continued From page 5 Resident #17 was readmitted back to the facility on 2/13/23. The Social Worker (SW) was interviewed on 3/7/23 at 10:55 AM. The SW stated that she was not responsible for notifying the resident or the responsible party (RP) when a resident was discharged to the hospital. The admission staff member was interviewed on 3/7/23 at 10:56 AM. She stated that she started working at the facility 2 weeks ago. She was responsible for notifying the resident or the RP when a resident was discharged to the hospital. She called the RP, discussed the bed hold policy and requested the RP to come to the facility to sign the bed hold form. She then provided the RP a copy of the form with the reason and the date the resident was discharged to the hospital. The Administrator was interviewed on 3/9/23 at 9:10 AM. She stated that the admission staff member was responsible for notifying the resident or the RP when a resident was discharged to the hospital. She added that the admission staff member called the RP, explained the bed hold policy and requested the RP to come to the facility and to sign the bed hold form. The form included the reason and the date the resident was discharged to the hospital. After the bed hold form was signed, a copy was provided to the RP. The Administrator further explained that when Resident #17 was discharged to the hospital, the previous admission staff member, who no longer worked at the facility, did not have the bed hold form completed and signed by the RP.	F 623		
F 641 SS=E	Accuracy of Assessments	F 641		3/28/23

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F 641	Continued From page 6 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Residents # 22, #4 & #1), accidents (Resident #4 & #26), diagnoses (Resident #4) and urinary status (Resident # 54) for 5 of 20 sampled residents whose MDS were reviewed. Findings included: 1 a. Resident # 4 was admitted to the facility on 7/10/18 with multiple diagnoses including congestive heart failure (CHF). Resident #4 had a physician's order dated 12/14/22 for Bumetanide (a diuretic drug) 1 milligram (mg.) by mouth twice a day for CHF. Review of the January 2023 Medication Administration Records (MARs) revealed that Resident #4 had received Bumetanide from January 1 through January 31, 2023. The annual MDS assessment dated 1/19/23 did not indicate that Resident #4 had received a diuretic medication during the assessment period. The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the physician's orders and the January 2023 MARs and verified that Resident #4 had received Bumetanide during the assessment period. He	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 ACCURACY OF ASSESSMENTS Corrective Action: Resident # 4: Resident Minimum Data Set (MDS) assessment (Annual Assessment,) with Assessment /Reference Date (ARD) [01/19/2023] was modified on 3/24/2024 by MDS Nurse Consultant. Resident # 22: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [01/19/2023] was modified on 3/24/2024 by MDS Nurse Consultant. Resident # 1: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [02/12/2023] was modified on 3/24/2024 by MDS Nurse Consultant.	

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F 641	Continued From page 7 reported that he missed to note on the annual MDS assessment dated 1/19/23 that Resident #4 had received a diuretic medication. b. Resident #4 had a physician's order dated 1/7/23 for Ertapenem (an antibiotic drug) 1 gram (gm) - 500 mgs. intramuscular (IM) in the evening for urinary tract infection (UTI) for 10 days. Review of the January 2023 Medication Administration Records (MARs) revealed that Resident #4 had received Ertapenem from January 7 through January 16, 2023. The annual MDS assessment dated 1/19/23 indicated that Resident #4 had received an antibiotic medication during the assessment period but did not indicate that the resident had a diagnosis of UTI. The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the physician's orders and the January 2023 MARs and verified that Resident #4 had received Ertapenem for UTI during the assessment period. He reported that he missed to note on the annual MDS assessment dated 1/19/23 that Resident #4 had a diagnosis of UTI. c. Review of the nurse's note and the incident report dated 1/1/23 at 11:15 AM revealed that Resident #4 was found on the floor. The resident complained of head, neck and back pain and noted to have a skin tear to the left shin. The annual MDS assessment dated 1/19/23 indicated that Resident #4 had no falls since admission/entry, reentry or prior assessment.	F 641	Resident # 26: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [02/10/2023] was modified on 3/24/2024 by MDS Nurse Consultant. Resident # 54: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [02/03/2023] was modified on 3/24/2024 by MDS Nurse Consultant. Identification of other residents who may be involved with this practice: All current residents who are receiving antidiuretic medication during assessment look back period, all current residents who have had a diagnosis of Urinary Tract Infection during the 30day look back of the assessment period, all current residents who have had a fall since admission/entry, reentry or prior assessment, All current residents who are receiving antibiotic medication during assessment look back period, All current residents who have a urinary catheter in place during the look back period of the assessment , have the potential to be affected by the alleged practice. On 3/22/2023 to 3/24/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have indwelling urinary catheters, have Section H0300: Urinary Continence coded accurately. Out of a total number of 4 current residents with indwelling urinary catheters, 0 out of 5 MDS assessments	

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F 641	Continued From page 8 The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the nurse's notes and verified that Resident #4 had a fall on 1/1/23. He reported that he missed to note on the annual MDS assessment dated 1/19/23 that Resident #4 had a fall. 2. Resident #22 was admitted to the facility on 10/20/19 with multiple diagnoses including hypertension. Resident #22 had a physician's order dated 8/26/22 for hydrochlorothiazide (a diuretic drug) 25 mgs by mouth in the evening for hypertension. The January 2023 Medication Administration Records (MARs) revealed that Resident #22 had received hydrochlorothiazide from January 1 through January 31, 2023. The quarterly Minimum Data Set (MDS) assessment dated 1/19/23 did not indicate that Resident #22 had received a diuretic medication during the assessment period. The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the physician's orders and the January 2023 MARs and verified that Resident #22 had received hydrochlorothiazide during the assessment period. He reported that he missed to note on the quarterly MDS assessment dated 1/19/23 that Resident #22 had received a diuretic medication. 3. Resident #1 was admitted to the facility on 11/18/2010 with multiple diagnoses including non-pressure chronic ulcer on the ankle.	F 641	were modified to reflect accurate data for section H0300: Urinary continence due to inaccuracy. Section H0300: Urinary Continence coded accurately for all 4 current residents with indwelling urinary catheters. On 3/22/2023 to 3/24/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have had a Urinary Tract Infection identified in the 60day look back period and whose diagnosis status is active in the last /within the 30day look back period have section I23000,urinary tract infection (UTI) coded accurately. Out of all the current residents, 3 out of 50 resident assessments completed in the last 3 months were modified to reflect accurate data for section I2300, Urinary tract infection. On 3/22/2023 to 3/24/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have had a fall in the last 6 months had section J1800;Any falls since admission/entry or reentry or prior assessment(OBRA or scheduled PPS) coded accurately. Out of all the current residents, 3 out of the 50 resident assessments completed in the last 3 months were modified to reflect accurate data for section J1800;any falls since admission/entry or reentry or prior assessment(OBRA or scheduled PPS). On 3/22/2023 to 3/24/2023 an audit was	

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F 641	Continued From page 9 Resident #1 had a physician's order dated 1/27/23 for Flagyl 500 milligrams (mgs) capsule-apply to ankle wounds topically every Monday, Wednesday, and Friday for wound care. Review of the February 2023 Medication Administration Records (MARs) revealed that Resident #1 had received Flagyl to her wounds every Monday, Wednesday, and Friday from February 1 through February 28, 2023. The quarterly Minimum Data Set (MDS) assessment dated 2/12/23 did not indicate that Resident #1 had received an antibiotic medication during the assessment period. The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the physician's orders and the February 2023 MARs and verified that Resident #1 had received Flagyl during the assessment period. He reported that he missed to note on the quarterly MDS assessment dated 2/12/23 that Resident #1 had received an antibiotic medication. 4. Resident # 26 was admitted to the facility on 8/26/22 with multiple diagnoses including hemiplegia affecting the left dominant side. Review of the nursing note and the incident report dated 12/26/22 at 1:20 PM revealed that Resident #26 was found on the floor in front of his wheelchair. The resident stated that he was trying to go back to bed. There was no injury noted. The quarterly Minimum Data Set (MDS) assessment dated 2/10/23 indicated that	F 641	completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have received antibiotic medication in the 7 day look back period of the assessment have section N0410F:Antibiotic. Out of all the current residents, 3 out of the 50 resident assessments completed in the last 3months were modified to reflect accurate data for section N0410F:Antibiotic. On 3/22/2023 to 3/24/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current residents who have received antidiuretic medication in the 7 day look back period of the assessment have section N0410G:Antidiuretic. Out of all the current residents, 0 out of the 50 resident assessments completed in the last 3months were coded accurately and reflect accurate data for section N0410G:Antidiuretic. This was completed on 03/24/2023. Systemic Changes: On 03/27/2024 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. The education focused on: The facility must ensure that each assessment accurately reflects the resident's status. Section H0300: Urinary Continence. Code	

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F 641	Continued From page 10 Resident #26 had no falls since admission/entry, reentry or prior assessment. The MDS Nurse was interviewed on 3/8/23 at 4:10 PM. The MDS Nurse reviewed the nurse's notes and verified that Resident #26 had a fall on 12/26/22. He reported that he missed to note on the quarterly MDS assessment dated 2/10/23 that Resident #26 had a fall. The Director of Nursing (DON) was interviewed on 3/9/23 at 8:15 AM. The DON reported that the MDS Nurse was brand new (started last summer), and he had no MDS experience. He is still learning MDS. 5. Resident #54 was admitted to the facility on 11/3/20 with diagnoses that included obstructive and reflux uropathy (a condition in which the flow of urine is blocked). A physician's order dated 7/10/22 indicated Resident #54 to have a urinary catheter for obstructive uropathy. Nursing notes dated 12/1/22 through 2/3/23 specified Resident #54 had a urinary catheter in place. A quarterly Minimum Data Set (MDS) assessment dated 2/3/23 revealed Resident #54 was cognitively intact. She was coded with an indwelling catheter and as frequently incontinent of bladder. Review of Resident #54's active care plan, last reviewed 3/4/23, included a focus area having an indwelling urinary catheter for obstructive uropathy.	F 641	9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days. Section I2300: urinary tract infection (UTI) . There are two look-back periods for this section: Diagnosis identification (Step 1) is a 60-day look-back period. Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period). Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent	

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F 641	Continued From page 11 During an interview with the MDS Nurse on 3/8/23 at 4:00 PM, he confirmed Resident #54 had an indwelling urinary catheter when the 2/3/23 MDS was completed, and it was an error to have coded her with bladder incontinence. This area should have been coded as "Not Rated". An interview was conducted with the Director of Nursing on 3/9/23 at 9:30 AM and she indicated it was her expectation for the MDS to be coded accurately.	F 641	discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available. Item I2300 Urinary tract infection (UTI): — The UTI has a look-back period of 30 days for active disease instead of 7 days. — Code only if both of the following are met in the last 30 days: 1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, AND 2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days. In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident. — Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI. — If the diagnosis of UTI was made	

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F 641	Continued From page 12	F 641	prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork. — When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI). A physician often prescribes empiric antimicrobial therapy for a suspected infection after a culture is obtained, but prior to receiving the culture results. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism. Section J1800;Any falls since admission/entry or reentry or prior	

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F 641	Continued From page 13	F 641	assessment(OBRA or scheduled PPS). If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes). Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record. Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to Prior Surgery item (J2000). Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent. Section N0410F, Antibiotic: Review the resident's medical record for documentation that any of these	

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F 641	Continued From page 14	F 641		

medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). Record the number of days an antibiotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
Section N0410G, Diuretic: Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). Record the number of days a diuretic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
This in service was completed by 03/27/2023.
Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive

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in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.
Monitoring:
To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that Section H0300: Urinary Continence, Section I2300: urinary tract infection (UTI), Section J1800;Any falls since admission/entry or reentry or prior assessment(OBRA or scheduled PPS). Section N0410F, Antibiotic: and Section N0410G, Diuretic: are coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager,

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F 641	Continued From page 16	F 641	Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 03/28/2023	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with newly evident diagnosis of mental illness for Preadmission Screening and Resident Review (PASARR) level II screen for 1 of 1 sampled resident reviewed for PASARR (Resident #7). Findings included: Resident # 7 was admitted to the facility on	F 644	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	3/28/23

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F 644	Continued From page 17 6/19/20 with PASARR level I screen which indicated the screen did not go to level II. Resident #7 had no mental health related diagnosis noted on admission to the facility. The psychiatric note dated 3/8/21 indicated that Resident #7 had a diagnosis of major depressive disorder and was on Zoloft and Doxepin for depression and Remeron for appetite stimulant. The note indicated to discontinue Doxepin as part of gradual dose reduction (GDR). The quarterly Minimum Data Set (MDS) assessment dated 4/9/21 indicated that Resident #7 had a diagnosis of depression and had received an antidepressant medication during the assessment period. The psychiatric note dated 5/3/21 revealed that Resident #7 continued to complain of bugs crawling underneath her skin and all over her body and bed. On examination, she appeared anxious and reported that she could feel and see the bugs on her body and placed them in a cup on the table. There was a cup on the table, but the resident would not allow the writer to look inside the cup. Risperdal was initiated to manage distressing psychotic symptoms that were impairing her function and a diagnosis of Schizophrenia spectrum disorder with psychotic disorder type was added to the diagnosis list. Resident #7 had a physician's order dated 5/3/21 for Risperdal (an antipsychotic drug) 0.5 milligrams (mgs) by mouth at bedtime for psychosis. The annual MDS assessments dated 6/17/21 and 5/30/22 revealed that Resident #7 had a	F 644	deficiencies cited have been or will be corrected by the date or dates indicated. F 644 COORDINATION OF PASARR AND ASSESSMENTS Corrective Action: Resident #7. Resident referred for level II Preadmission Screening and Resident Review (PASARR). Review completed. Resident remains as Level 1 PASARR. Identification of other residents who may be involved with this practice: All current residents with a newly evident diagnosis of serious mental illness have the potential to be affected by the alleged practice. On 03/24/2023 an audit was completed by the MDS Nurse consultant to ensure that the facility had referred resident(s) with diagnosis of serious mental illness present on admission for level II Preadmission Screening and Resident Review (PASARR). Out of 3 current residents have been referred for Level 11 Preadmission screening and resident review (PASARR). Systemic Changes: On 03/27/2023 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the	

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F 644	Continued From page 18 diagnosis of psychotic disorder and had received an antipsychotic medication during the assessment period. The assessments further indicated that the resident had not been evaluated by level II PASARR and determined to have a serious illness and or mental retardation. The Social Worker (SW) was interviewed on 3/8/23 at 11:38 AM. The SW stated that when a resident was newly diagnosed with a mental illness, the resident needed to be evaluated for a level II PASARR. The SW reviewed the medical records of Resident #7 and verified that Resident #7 was admitted with a level I PASARR. She stated that the resident was being followed by the psychiatric services and on 5/31/21, a new diagnosis of Schizophrenia spectrum disorder with psychotic disorder type was added. The SW indicated that if she had been made aware by the interdisciplinary team (IDT) of the new diagnosis, she would have made a referral for level II PASARR evaluation, but she was not. She confirmed that no referral for level II PASARR had been made for Resident #7. The Director of Nursing (DON) was interviewed on 3/9/23 at 8:15 AM. She stated that the Social Worker was responsible for making the referral for level II PASARR. She indicated that she expected the SW to make the referral when a resident had a new diagnosis of mental illness.	F 644	maximum extent practicable to avoid duplicative testing and effort. Coordination includes: Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual’s payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions). Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident’s physical or mental condition. Therefore, when an SCSA is completed for a resident	

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F 644	Continued From page 19	F 644	with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change This in service was completed by 03/27/2023. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records to ensure that a referral was made for resident with diagnosis of serious mental illness, present on admission or a newly diagnosed serious mental illness, for a level II PASARR (Preadmission screening and Resident Review). This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as	

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F 644	Continued From page 20	F 644	appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 03/28/2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and family and staff interviews, the facility failed to provide showers as scheduled for 1 of 5 sampled residents who needed extensive assistance or were dependent on the staff for activities of daily living (Resident #59). Findings included: Resident #59 was admitted to the facility on 4/21/21 with multiple diagnosis including hemiplegia/hemiparesis following cerebral infarction affecting the left dominant side and dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/29/23 indicated that	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 The facility failed to provide showers as scheduled for resident #59. 1. Corrective action for resident(s)	4/14/23

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F 677	Continued From page 21 Resident #59 had moderate cognitive impairment and she needed extensive assistance with personal hygiene and bathing. The assessment further indicated that the resident had no behaviors including rejection of care. Resident #59's care plan that was reviewed on 1/29/23 revealed that she had an activity of daily living (ADL) self -care performance deficit related to hemiplegia/hemiparesis. The approaches included "I required staff extensive assistance with grooming and personal hygiene". Review of the shower schedule revealed that Resident #59 was scheduled to have a shower twice a week on Monday and Thursday on 3-11 shift. Review of the nurse's notes from January 2023 through March 2023 revealed that Resident #59 did not have refusal of care. Resident #59 was observed in bed on 3/6/23 at 11:25 AM. The resident was clean and her hair was a litthe bit greasy. A family member was at bedside visiting. A family member of Resident #59 was interviewed on 3/6/23 at 11:28 AM. The family member voiced a concern that every time she visited, the resident's hair was greasy. The staff did not provide shower to the resident unless she/he asked for it. The family member reported that the resident was supposed to receive a shower twice a week but that was not happening. The shower documentation for the last 3 months was requested but the facility only provided one month of shower documentation (2/9/23 through	F 677	affected by the alleged deficient practice: A shower was provided to resident #59 on 3/09/2023 by the assigned Certified Nursing Assistant and documented as completed in the electronic health record by the assigned Certified Nursing Assistant. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/ 10/2023 the Director of Nursing and Nurse Managers audited showers for the last 3 days for documentation of the provision of a shower following the shower schedule. The results included: 87 showers. On 3/ 10 /2023 the identified residents received a shower and the shower was documented as completed in the electronic health record by the assigned Certified Nursing Assistant. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/23/2023, the Director of Nurses and Assistant Director of Nurses began education of all full time, part time, and PRN Nurses and Certified Nursing Assistant□s on the following: " Following the shower schedule as indicated in the Kardex. " Documentation of completion of the shower in the electronic health record. " Documentation of refusals and notification of the nurse/Responsible Party etc.	

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	345216	A. BUILDING _____ B. WING _____	C 03/09/2023

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F 677	Continued From page 22 3/6/23). Interview with the Administrator on 3/7/23 at 3:20 PM revealed that the computer would only allow the staff to pull 30 days of shower documentation. Review of the shower documentation from 2/9/23 through 3/6/23 revealed that Resident #59 had received a shower on 2/9, 2/20, 2/23, 2/27, 3/2 and 3/6/23. The resident missed her shower on 2/13, and 2/16. There was no documentation on the shower form that the resident had refused shower. Attempts to interview Nurse Aide (NA)#2, who was assigned to Resident #59 on 2/13/23 but was unsuccessful. NA #3, who was assigned to Resident #59 was interviewed on 3/8/23 at 3:50 PM. The NA stated that the resident seldom refused care, especially showers. If she refused shower and you tried to persuade her, most of the time she would allow you to give her a shower. The NA would not comment as to why the resident had missed some showers. The Director of Nursing (DON) was interviewed on 3/9/23 at 8:20 AM. The DON stated that she expected NAs to provide showers to the resident as scheduled and if the resident refused shower to document on the form. The DON also reported that the computer would not allow her to pull the shower documentation for more than 30 days.	F 677	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any nursing staff, to include agency, who does not receive scheduled in-service training will not be allowed to work until training has been completed by 4/14/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor shower compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/14/2023	

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F 686	Continued From page 23	F 686		
F 686 SS=E	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, observation, and interviews with the Physician, Wound Physician and staff, the facility failed to obtain an order for treatment to the left buttock pressure ulcer (Resident #4) and failed to ensure the alternating air mattress was functioning resulting in a deflated air mattress (Resident #29) for 2 of 3 sampled residents reviewed for pressure ulcers (Residents #4 & #29). Findings included: 1. Resident # 4 was admitted to the facility on 7/10/18 with multiple diagnoses including diabetes mellitus, thoracic, thoracolumbar, lumbosacral, and intervertebral disk disorder, stage 4 chronic kidney disease, and congestive heart failure (CHF). A review of Resident #4's weekly decubitus ulcer	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 On 3/10/23 the total body skin assessment revealed that Resident #4 has current wounds on the left and right buttocks and a treatment was in place that was being managed by the treatment nurse or the staff nurse according to the physician's order.	4/15/23

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F 686	Continued From page 24 assessments dated 1/11/23 revealed that Resident #4 had a stage 3 pressure ulcer on the right buttock measuring 2.7 centimeter (cm) by (x) 2.6 cm x 0.1 cm. with 25 % slough (dead tissue). Resident #4 had a physician order dated 1/11/23 to clean the right buttock pressure ulcer with wound cleanser, pat dry, apply hydrogel gauze (provides a moist wound environment for healing) and cover with dry dressing daily. On 2/2/23, the treatment to the right buttock pressure ulcer was changed to "clean with wound cleanser, apply Sulfadiazine (used to prevent/treat wound infections) and cover with dry dressing daily". Resident #4's care plan dated 1/11/23 was reviewed. One of the care plan problems was "I currently have a pressure ulcer to my right buttock, and I am at risk for development of additional pressure ulcers due to decreased ability to reposition and incontinence". The approaches included to administer treatments as ordered and monitor for effectiveness. The annual Minimum Data Set (MDS) assessment dated 1/19/23 indicated that Resident #4's cognition was intact, and she needed extensive assistance with bed mobility. The assessment further indicated that the resident had a stage 3 pressure ulcer that was not present on admission. The weekly pressure ulcer assessment dated 1/24/23 revealed that Resident #4 had developed a pressure ulcer on the left buttock. The assessment revealed a stage 3 pressure ulcer measuring 2.5 centimeter (cm) by (x) 1.3 cm x 0.1 cm. and the physician was notified.	F 686	On3/10/23 the Director of Nurses reviewed Resident #4's orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. Resident #29 On 3/10 /2023 the nursing team completed a head to toe skin assessment that revealed that resident has pressure wounds on right buttock. No new areas of skin integrity alteration were noted. On 3/10/2023 the Director of Nurse's reviewed the resident's current weight and adjusted the alternating pressure reducing air mattress setting accordingly, to assure the mattress setting was correct for Resident #29. On 3/10/23 the Director of Nurses reviewed Resident #29 orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds with no concerns identified. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/10/2023, the Director of Nurses began identification of residents that were potentially impacted by this practice by completing total body skin assessments on all current residents on 3/10/23. This audit was completed by reviewing 100% of current residents to identify any residents with new pressure wounds or skin integrity alterations. The results included: 12 residents with pressure	

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F 686	Continued From page 25 Review of Resident #4's physician's orders from January through March 2023 revealed no order for treatment to the left buttock pressure ulcer. The January through March 2023 Treatment Administration Records (TARs) were reviewed and there was no evidence that treatment was provided to the left buttock pressure ulcer from January 24, 2023 (pressure ulcer was first identified) through March 7, 2023. On 3/6/23 at 10:05 AM, Resident #4 was observed in bed. She had an air mattress, and she was positioned to her right side. She stated that she had pressure ulcers on her buttocks and the nurses had changed the dressing every day and had turned her from side to side. On 3/7/23 at 4:30 PM, Resident #4 was observed during the dressing change. The resident was observed to have open areas on the right and left buttocks. The Treatment Nurse was observed to clean the pressure ulcers on the right and left buttocks with wound cleanser, Sulfadiazine was applied to both areas and covered with a foam dressing. On 3/8/23 at 1:20 PM, the Treatment Nurse was interviewed. She stated that she started as Treatment Nurse a month ago. She assessed Resident #4's pressure ulcers weekly and provided the treatment on both buttocks daily. She verified that Resident #4 had stage 3 pressure ulcers on her right and left buttocks. She stated that the previous treatment nurse had notified the Physician and the responsible party of the pressure ulcer on the left buttock. The Treatment Nurse reviewed the physician's orders	F 686	ulcers. On 3/10/23, the Director of Nurses assessed and audited 100% of all current pressure wounds to assure current wound measurements were completed. The results included: 12 residents with pressure ulcers. On 3/10/2023, the Director of Nursing audited 100% of all residents with identified pressure wounds to assure a current treatment order were correct and in place on the electronic treatment record. The results included: 12 residents with current orders. On 3/10/2023 the Director of Nursing completed a 100% audit of all resident Braden scores for risk for pressure ulcers. The results included: 69 residents total and 39 residents were at risk for skin break down. On 3/10/2023, 100% of residents with pressure wounds or at risk for pressure ulcers were audited by the Minimum Data Set nurse to ensure preventative measures were currently in place to prevent new skin breakdown and address the current pressure wound. The results included: For Resident # 29 on 3/10 /2023 the nursing team audited all residents with ordered alternating pressure reducing air mattresses to assure that the mattress was at the correct setting based on the resident's weight. Results: As of 3/10 /2023 all residents with ordered alternating pressure reducing air mattresses were in compliance. On 3/10/2023 the Director of Nurses educated the wound nurse on the	

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F 686	Continued From page 26	F 686		

and the TARs and reported that she did not realize that there was no treatment ordered for the left buttock pressure ulcer and there was no evidence on the TARs that the treatment was provided. She reported that she used Sulfadiazine to treat the pressure ulcers on the resident's right and left buttocks. The Treatment Nurse reported that the ulcers on the resident's buttocks were improving. The Treatment Nurse explained that she provided the treatment to the left buttock Monday through Friday and the nurses who were assigned to Resident #4 provided the treatment on Saturday and Sunday. She reported that she could tell that the treatment was provided to the left buttock on the weekends by the date of the dressing.

On 3/9/23 at 8:15 AM, the Director of Nursing (DON) was interviewed. She stated that the weekly assessments indicated that the Physician was aware of the pressure ulcers on the right and left buttocks. The DON indicated that it was an oversight on the part of the Treatment Nurse for not ensuring that there was a treatment ordered for the left buttock pressure ulcer and for not ensuring there was a treatment transcribed and documented on the TARs. She reported that the treatment was provided to the left buttock, and the pressure ulcer was improving. The DON indicated that she expected an order for treatment for each pressure ulcer.

The Physician was interviewed on 3/9/23 at 9:20 AM. The Physician stated that Resident #4 was a high risk for pressure ulcer due to her comorbidities and her age. He indicated that he expected the Treatment Nurse to obtain a treatment order for each pressure ulcer and she might have obtained the order but forgot to write it

expectation that alternating pressure reducing mattresses will be set following the manufacturer recommends and the resident's weight.
On 3/ 10 /2023 the DON/RN Manager audited administered documented wound treatments for compliance the last 3 days. The results included:
As of 3/ 10/2023 all wound treatments were in compliance.

2. Systemic changes
Root Cause Analysis was completed on 3/10/2023 with the following staff in attendance: Administrator, Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was done related to not clarifying that there is a physician's treatment order for each wound. Ensuring the accurate and correct order is transcribed and followed by the nurse's providing treatments to the wounds and initiate interventions/treatments for a resident at risk for skin breakdown. Upon interview of the nursing staff/agency it was determined that the root cause was the facility administration failure to provide effective oversight and leadership to ensure effective systems were in place to:
Provide wound care and dressing changes per physician's orders. Review and provide needed treatment from physician referrals regarding identified wounds. Ensure physician's orders for wound care were followed.

On 3/10/2023, the Director of

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F 686	Continued From page 27 down. He also stated that most of the time if the ulcers were on the same area, the order for treatment was the same. 2. Resident #29 was admitted to the facility on 5/27/14. Her diagnoses included type 2 diabetes, and Alzheimer's disease. A review of the active physician orders included an order dated 6/30/21 for a "low loss air mattress for pressure ulcer protection/preventive and comfort. Maintain proper function every shift. Air mattress settings should be semi firm (dial settings should be at 12 o'clock position)". A quarterly Minimum Data Set (MDS) assessment dated 1/10/23 indicated Resident #29 had severe cognitive impairment. She was coded as having a pressure ulcer over a bony prominence and one stage 3 pressure ulcer. She had a pressure reducing device to the bed. A review of Resident #29's active care plan, last reviewed 1/18/23, included the following focus areas: - Risk for pressure ulcer development due to decreased ability to assist with repositioning. The interventions included a low loss air mattress to the bed for pressure prophylaxis (pressure injury prevention). - Currently have a pressure ulcer to the right buttock, gluteal fold related to immobility. One of the interventions was an air mattress to the bed. - Activities of Daily Living (ADL) self-care performance deficit related to dementia and overall weakness. The interventions included an air mattress. A review of Resident #29's medical record from 12/13/22 to 3/6/23 revealed wound care was	F 686	Nurses/Quality Assurance Nurse Consultant/Senior Regional Staff Education Specialist began in-service of 100% of all licensed nurses, full time, part time, as needed nurses, including agency to include: Identification of New Orders and Provision of Ordered Treatments. Wound/Skin/Treatment/Order Documentation Process. The Post Follow Up of Appointment Orders Process and the Order Clarification Process. Documentation and notification of the Administrator/Director of Nurses if a treatment cannot be completed for any reason. On 03/10/23 education was initiated by the Staff Development Coordinator/Director of Nursing for 100% of all licensed nurses, including agency nurses, on the Nurse Practice Act and North Carolina Board of Nursing Position statement on Wound Care. In addition, on 03/10/23, the Staff Development Coordinator and Director of Nursing began direct observation, with return demonstration, of how to complete a skin assessment/wound assessment utilizing a competency check list of the steps of the skin/wound/order/treatment process and the nurses were instructed to identify on the skin assessment, for residents with immobilizers/braces, the condition of the skin under or surrounding the immobilizer or brace. Including notification of the physician and wound nurse for further and assessment and treatment orders for any new or worsening changes to the skin.	

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F 686	Continued From page 28 provided to a right buttock pressure ulcer. On 3/6/23 at 10:20 AM, an observation was made of Resident #29 while she was lying in the bed. A hissing sound was coming from the air mattress machine that was hooked to the foot of the bed. Upon observation the bottom connector of the air mattress was dislodged from the machine. Resident #29 was lying on the deflated air mattress. Another observation was made of Resident #29 on 3/6/23 at 12:03 PM while she was lying in bed. The air mattress bottom connector was not connected to the machine and Resident #29 was lying on the deflated air mattress. On 3/7/23 at 8:35 AM, Resident #29 was observed while being assisted with her breakfast meal by Nurse Aide (NA) #1. The bottom connector on the air mattress machine remained dislodged and Resident #29 was lying on the deflated air mattress. NA #1 stated the nurses monitored the air mattress functionality. Another observation was made of Resident #29 while she was lying in bed on 3/7/23 at 2:19 PM. The bottom connector remained unconnected to the machine and Resident #29 was on the deflated air mattress. On 3/7/23 at 3:19 PM, an observation of Resident #29 occurred with Nurse #1, who verified the bottom connector of the air mattress was not connected to the machine and Resident #29 was lying on the deflated air mattress overlay in the bed. Nurse #1 stated when she signed on the Treatment Administration Record (TAR) it was indicating that the air mattress settings were in	F 686	As of 3/10/23 the Quality Assurance Nurse Consultants educated the Director of Nursing and Staff Development Coordinator educated and they began education of all licensed nurses, including agency on the following expectations: the wound nurse or nurse assigned is to complete the weekly pressure ulcers assessment after rounding with the wound doctor. The nurse is responsible to look at the User Defined Assessment in the electronic medical record in order to complete the weekly skin assessment timely. All orders are to be transcribed by the nurse who receives the order. If the nurse needs clarification of the order, the nurse is to contact the physician for clarity of the order. During morning clinical meeting all orders are to be reviewed to ensure clarity. All Staff would be expected to do daily monitoring of the high-risk skin area. Certified Nursing Assistants are to report noted skin integrity alterations to the nurse. As of 3/14/2023, no Licensed Nurses or Certified Nursing Assistants will work without the education/training and competency check off list completed. This is to include agency and new staff. The Director of Nurses and Administrator are responsible to ensure all staff are educated as well as to maintain monitoring and tracking of sustained compliance for staff that still require education to include newly hired licensed nurses, Certified Nursing Assistants and	

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F 686	Continued From page 29 the correct position. She added she did not visualize the connectors or if the overlay was inflated. The Wound Physician was interviewed on 3/9/23 at 9:00 AM and stated she would expect the air mattress to be connected and functioning properly as Resident #29 currently had a pressure ulcer to her buttock area and remained at high risk for further skin breakdown.	F 686	agency. After 3/14/23 the Staff development coordinator will be responsible to ensure any new Licensed Nurses, agency and Certified Nursing Assistances are educated on the applicable policies and procedures related to skin/wound care and the serious complications that might occur for failing to identify and treat a wound in a timely manner to include completion and documentation of ordered wound treatments and appropriately monitoring the functioning/setting of ordered specialty mattresses. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 03/26/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. 3. Quality Assurance monitoring procedure. Utilizing the F686 Quality Assurance Audit Tool, the Director of Nurses or designee will monitor the post appointment process/treatment administration and documentation process and the specialty mattress process for compliance weekly x 4 weeks then monthly x 3 months or until resolved. Appointment follow up will be monitored as part of the Daily Clinical Meeting. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective	

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F 686	Continued From page 30	F 686	action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager DOC: 04/15/2023	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure oxygen therapy was provided as ordered by the physician for 1 of 4 sampled residents for respiratory care (Resident #33). The findings included: Resident #33 was admitted to the facility on 07/02/21 with diagnoses which included Chronic Obstructive Pulmonary Disease, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen.	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695	4/14/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 Review of the significant change Minimum Data Set (MDS) assessment dated 12/20/22 revealed Resident #33 was cognitively intact. She required extensive assistance with 2 people with bed mobility, dressing, and toilet use. She was coded as utilizing oxygen. Resident #33's care plan dated 05/11/22 revealed she required oxygen therapy due to congestive heart failure. The goal included she would have no signs or symptoms of poor oxygen absorptions through the review date. Interventions, in part, included oxygen settings are based on physician orders and observe for signs and symptoms of respiratory distress and report to physician. Review of Resident #33's physician orders dated 12/13/22 revealed supplemental oxygen to be delivered at 2 liters per minute via cannula. On 03/06/23 at 10:21 AM, Resident #33 was observed lying in the bed receiving humidified oxygen at 2.5 liters per minute via nasal cannula when viewed horizontally, eye level. On 03/07/23 at 8:33 AM, Resident #33 was observed lying in the bed receiving humidified oxygen at 2.5 liters per minute via nasal cannula when viewed horizontally, eye level. On 03/08/23 at 8:25 AM Resident #33 was observed lying in the bed receiving humidified oxygen at 2.5 liters per minute via nasal cannula when viewed horizontally, eye level. An observation was made with Nurse #4 of Resident #33's oxygen concentrator on 03/08/23 at 08:30 AM, who stated the oxygen regulator on the concentrator was set at 2 liters when she	F 695	The facility failed to ensure oxygen therapy was provided as ordered by the physician for 1 of 4 sampled residents. Corrective action for resident(s) affected by the alleged deficient practice: For resident #33, on 03/ 08/23 the oxygen concentrator flow rate was set for 2 liters per minute per the physician orders by the assigned nurse. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/ 09/2023 the Director of Nurses completed an audit of all current residents receiving Oxygen Therapy to ensure the Oxygen Concentrator is set at the correct flow rate as prescribed by the physician. 0 concentrators needed correction. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/23/2023, the Director of Nurses/ Assistant Director of Nurses began education of all full time, part time, and PRN Nurses (including agency) on the following: " Oxygen Concentrator are to be set at the flow rate ordered by the physician. " The Oxygen Concentrator Setting will be verified by the nurse every shift to ensure the resident is receiving the oxygen and the correct flow rate. " To verify the Setting Level the nurse	

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F 695	Continued From page 32 viewed it while she stood over the machine. She stated she quickly checked the flow rate earlier in the morning at eye level and stated it was 2 liters per minute. Then Nurse #4 viewed the oxygen regulator on the concentrator at eye level and adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #4 stated she did not know why the oxygen regulator was set at 2.5 liters. During an interview with the Director of Nursing on 03/03/23 at 11:15 AM, nurses should view the oxygen regulator on the concentrator at eye level to determine if it was set at the correct flow rate. The Administrator was interviewed on 03/08/23 at 1:05 PM. She stated physician orders should be followed at the correct oxygen flow rate.	F 695	must be eye level with the setting screen to ensure it is the correct dose. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and Certified Nursing Assistants who give residents care in the facility. As of 3/14/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor the Oxygen Concentrator flow rate to assure it is being provided as ordered. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly	

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F 695	Continued From page 33	F 695	QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: April 14, 2023 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 The facility failed to provide the resident and or responsible party (RP) with written notification for a transfer to the hospital for 2 of 3 residents. Corrective action for resident(s) affected by the alleged deficient practice On 3/ 10 /2023 written notification of the reason for hospital transfer was mailed to the responsible party for resident # 54 and # 17 by the social service director. Corrective action for residents with the potential to be affected by the deficient practice On 3/ 10 /2023, the Administrator and Social Service Director completed a 100 % audit of discharges for the last 14 days to ensure that there were no discharges that didn□t have a written notification sent or provided to the resident and/or	

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F 695	Continued From page 34	F 695	responsible party. The results included: 15 discharges. On 3/ 10 /2023 written notification of the reason for transfer to the hospital was sent to all above identified responsible parties and or residents by the 3/14/23 Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/ 10 /23, the Regional Operations Manager provided education to the Administrator, Business Office Manager, and Social Services Director. All training was completed by 3/ 14 /23. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing F-tag 623 Notice Requirements before Transfer monitoring QA tool. Observation will include review of all transfers for 4 resident□s weekly x 4 and then monthly x 3 or until resolved. The ongoing auditing program reviewed at the monthly Quality Assurance Meeting until deemed as no longer necessary for compliance. Date of compliance: 4/14/2023.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		4/15/23

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F 757	Continued From page 35 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, Nurse Practitioner, Medical Director and staff interviews, the facility failed to hold diabetic medications (Residents #18 and #42) and blood pressure medications (Residents #42 and #22) as ordered by the physician for 3 of 6 residents whose medications were reviewed. The findings included: 1. Resident #18 was admitted to the facility on 7/29/20 with diagnoses that included type 2 diabetes. A Significant Change in Status Minimum Data Set (MDS) assessment dated 11/22/22 indicated Resident #18 was cognitively intact. Review of Resident #18's February 2023 and March 2023 physician orders included an order for Levemir Solution (a diabetic medication) 100	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F757 Resident # 18 and Resident #24 Diabetic Medication Resident # 42 and Resident # 22 Blood Pressure Medication Corrective action was on obtained on 3/9/23 for both Residents #18 and Resident #24 to ensure parameters on diabetic medication administration orders	

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F 757	Continued From page 36 unit per milliliter. Inject 5 units subcutaneously in the morning for diabetes. Please hold for blood sugar less than 120. The February 2023 and March 2023 Medication Administration Records (MARs) were reviewed and revealed Resident #18 had received Levemir, despite the blood sugar less than 120 on the following dates: - 2/7/23- blood sugar was 109. - 2/23/23- blood sugar was 116. - 3/1/23- blood sugar was 116. - 3/2/23- blood sugar was 104. - 3/3/23- blood sugar was 98. An interview occurred with Nurse #1 on 3/8/23 at 12:56 PM, who was assigned to Resident #18 on 2/7/23, 2/23/23, 3/1/23 and 3/2/23. Nurse #1 indicated she was aware of the parameters to hold the Levemir. She reported she obtained the blood sugar and recorded on the MAR. Nurse #1 reviewed the February 2023 and March 2023 MARs, verified the Levemir was documented as administered despite the blood sugar being less than 120 when it should have been held and responded it was an oversight. The Nurse Practitioner (NP) was interviewed via the phone on 3/9/23 at 9:15 AM and stated she would expect the nurses to follow the orders for the Levemir parameters as written. Attempts to contact Nurse #3 were made without success. She was assigned to Resident #18 on 3/3/23. 2. Resident #42 was admitted to the facility on 9/12/22 with diagnoses that included Atrial	F 757	were transcriber correctly on the Medication Administration Record. Corrective Action was obtained on 3/9/23 for both Resident #42 and Resident #22 to ensure parameters were in place for Blood Pressure Medication and administration orders were transcribed correctly on the Medication Administration Record. On 3/10/2023 the Director of Nursing /Nursing Team began auditing of the 24 hour report in Real Time for change in condition to include B/P parameters and administration orders followed and Diabetic Medication parameters and administration orders followed. The results for the last 14 days to assure that the M.D. /RP had timely notification of changes that impacted the administration of medications that included parameters. Results: 7 out of 8 incidences of B/P and 0 Diabetic Medication incidence that were out of the normal range occurred without notification of the MD. On 3/10/2023 the Director of Nurses/Nursing Team audited all resident admit/readmit orders with parameters for the last 14 days for compliance with the administration of the medication following the ordered parameters. Results: all resident orders with parameters for the last 14 days for compliance with the administration of the medication following the ordered parameters. Results: 7 out 8 resident were given medications out of compliance. As of 3/10/2023 all resident□s medication administrations	

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F 757	Continued From page 37 Fibrillation, heart disease, congestive heart failure, and type 2 diabetes. A quarterly Minimum Data Set (MDS) assessment dated 12/20/22 indicated Resident #42 had moderately impaired cognition. a. Review of Resident #42's active physician orders included an order dated 10/28/22 for Metformin (a diabetic medication) 250 mg one tablet by mouth twice a day for diabetes. Hold for blood sugar less than 110. The March 2023 MAR was reviewed and revealed Resident #42 had received Metformin, despite the blood sugar being less than 110. - 3/5/23 the blood sugar was 108. An interview occurred with Nurse #2 on 3/8/23 at 2:00 PM, who was assigned to Resident #42 on 3/5/23. Nurse #2 reported she took the blood sugar and recorded it on the MAR. She reviewed the March 2023 MAR and verified the Metformin was administered despite the blood sugar being below 110 when it should have been held and felt it was an oversight. The Nurse Practitioner (NP) was interviewed via the phone on 3/9/23 at 9:15 AM and stated if Resident #42 had received a dosage of Metformin outside the parameter it should not have caused any serious harm. The NP added she would have expected the nurses to follow the orders for the Metformin parameters as written. b. Review of Resident #42's active physician orders included an order dated 9/30/22 for Metoprolol (a blood pressure medication) 25	F 757	with parameters were in compliance. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 3/10/2023, the Director of Nurses began identification of residents including new admits and readmits that were potentially impacted by this practice by audit of all Medication Administration Records x 14 days This audit was completed by reviewing 100% of current residents orders to ensure residents were set parameters for Medication Administration were transcribed correctly to the Medication Administration Record. The results included: On 3/ 10 /2023 the DON/RN Manager audited the Medication Administration Records of all resident with Medication Administration Parameters were documented for compliance the 14 last days. The results included: As of 03/ 14/2023 all Medication with administration parameters were in compliance. 2. Systemic changes Education On 3/10/2023 the DON/SDC began education of all full time, part time, as needed licensed nurses and agency nurses on the prevention of medication errors and medication safety to include facility policy on compliance with medication orders that contain parameters for administration and the	

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F 757	Continued From page 38 milligrams. Give half a tablet by mouth every 12 hours for high blood pressure. Hold for systolic blood pressure (SBP) less than 100, diastolic blood pressure (DBP) less than 55, heart rate less than 55. The February 2023 Medication Administration Record (MAR) was reviewed and revealed Resident #42 had received Metoprolol, despite the SBP less than 100 and DBP less than 55. - 2/20/23 SBP was 98 and DBP was 52. - 2/25/23 SBP was 88. A phone interview occurred with Nurse #5 on 3/8/23 at 2:17 PM, who was assigned to Resident #42 on 2/25/23. The February 2023 MAR was reviewed with Nurse #5 and stated the medication should have been held per the parameters and felt it was an oversight. The NP was interviewed via the phone on 3/9/23 at 9:15 AM and stated if Resident #42 had received a few dosages of Metoprolol outside the parameters it should not have caused any serious harm. The NP added she would have expected the nurses to follow the orders for the Metoprolol parameters as written. Attempts to contact Nurse #6 were made without success. She was assigned to Resident #42 on 2/20/23. 3. Resident # 22 was admitted to the facility on 10/20/19 with multiple diagnoses including hypertension. Resident #22 had a physician's order dated 8/26/22 for hydrochlorothiazide (can treat hypertension and fluid retention) 25 milligrams (mgs) - give 1 tablet by mouth in the evening.	F 757	notification of the MD and RP process. The DON will ensure that any of the above identified staff who does not complete the in-service training by 03/26/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation for the above identified staff. 3. Quality Assurance Plan: The Director of Nursing /Staff Development Coordinator will monitor this utilizing the Medication Order Parameter Quality Assurance Tool for Monitoring. The monitoring will include review of 4 residents using change in condition alerts during Daily QOL (Monday-Friday) and ordered medications with parameters for compliance with the identification of change in condition, compliance with the notification process and compliance with facility policy on the administration of medications with ordered parameters weekly x 2 weeks and then monthly for 3 months or until resolved by the Quality Assurance (QA) Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy, HIM, and Dietary Manager. DOC: 04/15/2023	

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Hold for systolic blood pressure (SBP) of less than or equal to 130.

The Medication Administration Records (MARs) from October through March 2023 were reviewed and revealed that hydrochlorothiazide was administered despite the blood pressure was less than 130 on the following dates:

10/5/22 - blood pressure (BP) 122/57
10/23/22 - BP 114/68
10/14/22 - BP 110/54
10/28/22 - BP 125/85
10/21/22 - BP 117/58
10/29/22 - BP 125/70
11/2/22 - BP 121/66
11/10/22 - BP 104/65
11/4/22 - BP 101/62
11/12/22 - BP 107/59
11/6/22 - BP 114/52
11/14/22 - BP 100/52
11/7/22 - BP 114/62
11/15/22 - BP - 100/52
11/8/22 - BP 101/61
11/17/22 - BP - 120/53
11/19/22 - BP 123/52
11/24/22 - BP 124/72
11/22/22 - BP 111/70
11/26/22 - Bp 129/65
11/23/22 - BP 107/68
12/4/22 - BP 119/73
12/7/22 - BP 126/68
12/8/22 - Bp 120/81
12/9/22 - BP 118/80
12/10/22 - BP 95/50
12/11/22 - BP 95/50
12/16/22 - BP 118/62
12/26/22 - BP 105/66
12/27/22 - BP 114/57

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12/30/22 - BP 112/60
1/1/23 - BP 127/75
1/16/23 - BP 107/60
1/18/23 - BP 107/60
1/21/23 - BP 112/66
1/30/23 - BP 118/66
2/1/23 - BP 123/54
2/3/23 - BP 128/66
2/5/23 - BP 130/68
2/6/23 - BP 122/67
2/13/23 - BP 126/74
2/14/23 - BP 127/79
2/22/23 - BP 122/50
3/2/23 - BP 128/64

Nurse #2, assigned to Resident #59 on 3/2/23 was interviewed. She reviewed the physician's order for the hydrochlorothiazide and stated that she was aware of the parameters to hold the medication if the SBP was below 130 but obviously she missed to hold the medication when the resident's blood pressure was 128/64 on 3/2/23.

Attempts to interview Nurse #6, who was assigned to Resident #59 on 2/13/23 and 2/22/23 but was unsuccessful.

The Pharmacy Consultant was interviewed on 3/8/23 at 3:05 PM. She reported that she identified the irregularity regarding the physician's order to hold the hydrochlorothiazide was not being followed. The Pharmacy Consultant reported that she brought it to the attention of the Director of Nursing (DON) on 6/22/22, 10/5/22 and on 3/6/22.

Nurse #8, who was assigned to Resident #59 on 1/23/23, 1/27/23, 1/30/23, 2/5/23, and 2/6/23 was

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F 757	Continued From page 41 interviewed on 3/9/23 at 8:14 AM. She reviewed the order for the hydrochlorothiazide and indicated that she was aware of the order to hold the medication if the SBP was 130 or below. Nurse #8 reviewed the MARs and stated, "I just don't know what to say, I missed it". The Director of Nursing (DON) was interviewed on 3/9/23 at 8:15 AM. She stated that she expected the nurses to follow the physician's orders in holding the medications with parameters. She reported that she provided education to the nurses when she received the report from the Pharmacy Consultant. The Physician was interviewed on 3/9/23 at 9:20 AM. He stated that he expected the nurses to follow the order in holding the BP medications with parameters.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		4/15/23

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F 842	Continued From page 42 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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	345216	A. BUILDING _____ B. WING _____	C 03/09/2023

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F 842	Continued From page 43 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to have accurate and complete medical records in the areas of pressure ulcers (Resident #4), wound care (Resident #29) & splint application (Resident #1) for 3 of 20 sampled residents whose medical records were reviewed (Residents # 1, # 4 & #29). Findings included: 1. Resident # 4 was admitted to the facility on 7/10/18. A review of the weekly decubitus ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) assessments was conducted. The assessment revealed that Resident #4 had developed a stage 3 pressure ulcer on the left buttock on 1/24/23. Review of the physician's orders from January 2023 through March 2023 revealed there was no treatment ordered for the stage 3 pressure ulcer on the left buttock. Review of the January through March 2023 Treatment Administration Records (TARs)	F 842	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F842 Resident records The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to have accurate and complete medical records in areas of pressure ulcer resident #4, wound care resident #29 and splint application resident #1 for 3 of 20 sampled residents. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/ 10/2023 the Director of Nursing and Nurse Managers audited MAR/TARS for the last 3 days for documentation of the	

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F 842	Continued From page 44 revealed there was no evidence that treatment was provided to the left buttock pressure ulcer. On 3/7/23 at 4:30 PM, Resident #4 was observed during the dressing change. The resident was observed to have open areas on the right and left buttocks. The Treatment Nurse was observed to clean the pressure ulcers on the right and left buttocks with wound cleanser, Sulfadiazine (used to treat and prevent wound infection) was applied to both areas and covered with a foam dressing. On 3/8/23 at 1:20 PM, the Treatment Nurse was interviewed. She verified that Resident #4 had stage 3 pressure ulcers on her right and left buttocks. The Treatment Nurse reviewed the physician's orders and the TARs and reported that she did not realize that there was no treatment ordered for the left buttock pressure ulcer and there was no evidence in the TARs that the treatment was provided. She reported that the treatment to both left and right buttocks was provided 7 days a week as ordered. On 3/9/23 at 8:15 AM, the Director of Nursing (DON) was interviewed. The DON indicated that it was an oversight on the part of the treatment nurse for not writing the treatment order for the left buttock pressure ulcer and therefore there was no treatment transcribed to the TARs. She reported that the treatment was provided to the left buttock, however, it was not documented on the TARs. 2. Resident #1 was admitted to the facility on 11/18/10. The quarterly Minimum Data (MDS) assessment	F 842	wound care, pressure ulcer documentation and splint application. On 3/ 10 /2023 the identified residents families□ provider were notified of omitted documentation. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 03/23/2023, the Director of Nurses, staff development coordinator began education of all full time, part time, and PRN Nurses on the following: " Following doctor□s orders for pressure ulcer documentation, wound care documentation and splint application. " Documentation of completion of pressure ulcer, wound care and splint application documentation in the electronic health record. " Documentation of refusals and notification of the physician and responsible Party etc. 1. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F842 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor documentation compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the	

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F 842	Continued From page 45 dated 2/12/23 indicated that Resident #1's cognition was intact. Resident #1 had a physician's order dated 11/11/22 to wear bilateral hand splints at night as tolerated and to remove in AM before meal. Resident #1 was observed on 3/6/23 at 1:25 PM with her right and left hands in a fist position. There was no device noted on both hands. The resident was interviewed and stated that the splints were applied at night. Review of the January, February and March 2023 Medication Administration Records (MARs) revealed multiple boxes with no nurse's initials to indicate that the splints were applied as ordered on the following dates: 1/2, 1/9, 1/10, 1/11, 1/13, 1/14, 1/15, 1/16, 1/23, 1/24, 1/25, 1/27, 1/28, 1/30, 2/6, 2/7, 2/8, 2/10, 2/11, 2/12, 2/14, 2/16, 2/21, 2/22,2/24, 2/25, 2/26 and 3/2/23. An attempt was made to interview Nurse #6 who was assigned to Resident #1 on 3/2/23 but was unsuccessful. Nurse #7 was interviewed on 3/7/23 at 10:16 AM. She stated that she worked night shift. Nurse #7 was assigned to Resident #1 on 1/9, 1/10, 1/11, 1/13, 1/14, 1/15, 1/16, 1/23, 1/24, 1/25, 1/27, 1/28, 2/6, 2/7, 2/8, 2/10, 2/11, 2/12, 2/22 and 2/25/23. She stated that she was aware that Resident #1 had an order for splints to be applied at night. Nurse #7 reported that she applied the splints every night and she did not know why the MARS were not signed off. She stated that she might have missed to sign them. The Director of Nursing (DON) was interviewed	F 842	ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/15/2023	

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on 3/9/23 at 8:15 AM. The DON stated that Nurse #6 and Nurse #7 were both agency nurses. She indicated that the nurses were applying the splints as ordered but she expected them to document to ensure complete and accurate medical records.

3. Resident #29's physician orders revealed the following:

- An order dated 1/12/23 to cleanse stage 3 pressure ulcer to the right buttock with normal saline. Apply Santyl to the wound bed and cover with a foam dressing every day. This order was discontinued 2/23/23.
- An order dated 2/24/23 to cleanse the right buttock with wound cleanser. Apply Collagen sheet to wound bed and cover with dry dressing on Monday, Wednesday, Friday and as needed. This was discontinued 2/28/23.
- An order dated 2/25/23 to cleanse the skin tear to the left outer knee, apply Vaseline gauze and cover with dry dressing until healed every day.
- An order dated 2/28/23 to cleanse the right buttock pressure ulcer with normal saline. Apply Medihoney gel to the wound bed, top with Calcium Alginate and cover with dry dressing. Change Monday, Wednesday, Friday and as needed. This order was discontinued on 3/3/23.
- An order dated 3/3/23 to cleanse the stage 3 pressure ulcer to the right buttock with saline. Apply Santyl to the wound bed, add Calcium Alginate and cover with a dry dressing every day.

The February 2023 and March 2023 Treatment Administration Records (TARs) were reviewed and revealed the following:

- The stage 3 pressure ulcer to Resident #29's right buttock had not been documented as completed or refused by the resident on 2/8/23, 2/23/23, 3/3/23 and 3/5/23.

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F 842	Continued From page 47 - The skin tear to the left outer knee was not documented as completed or refused by the resident on 3/5/23. Review of the nursing progress notes from 1/10/23 until 3/8/23 revealed Resident #29 accepted wound care. On 3/8/23 at 1:10 PM, the Treatment Nurse was interviewed and explained she became the Treatment Nurse towards the end of February 2023. She stated Resident #29 she completed wound care to Resident #29 but had forgotten to document the wound care as completed on the TAR for 2/23/23 and 3/3/23. The Treatment Nurse added the former wound care nurse would have been responsible for the wound care on 2/8/23. Nurse #2 was interviewed on 3/8/23 at 2:00 PM and reviewed the March 2023 TAR. She verified caring for Resident #29 on 3/5/23 and completed the wound care. Nurse #2 added she had forgotten to sign the wound care as completed on the TAR. An interview occurred with the Director of Nursing on 3/9/23 at 9:30 AM and indicated she expected the nursing staff to complete wound care as ordered as well as to document it was completed or refused by the resident.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including	F 867		4/15/23

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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 aimed at performance improvement and, after

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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 number and frequency of improvement projects

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F 867	Continued From page 50 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 record reviews, observations, Nurse Practitioner, Medical Director, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey on 7/1/21. This was for four deficiencies that were cited in the areas of Accuracy of Assessments, Activities of Daily Living Care Provided to Dependent Residents, Treatment/Services to	F 867	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	

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F 867	Continued From page 51 Prevent/Heal Pressure Ulcers and Drug Regimen is Free From Unnecessary Drugs. The duplicate citations during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: These citations are cross referenced to: 1. F641- Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Residents # 22, #4 & #1), accidents (Resident #4 & #26), diagnoses (Resident #4) and urinary status (Resident # 54) for 5 of 20 sampled residents whose MDS were reviewed. During the facility's recertification survey of 7/1/21, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of accidents, nutrition, and diagnoses for 3 of 19 sampled residents reviewed. In an interview with the Administrator on 3/9/23 at 9:00 AM, she felt the repeat citation in MDS accuracy was felt to be related to human error. 2. F677- Based on record review, observation and family and staff interviews, the facility failed to provide showers as scheduled for 1 of 5 sampled residents who needed extensive assistance or were dependent on the staff for activities of daily living (Resident #59). During the facility's recertification survey of 7/1/21, the facility failed to provide nail care for a resident dependent on staff for assistance with	F 867	corrected by the date or dates indicated. F867 QAPI PROGRAM The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions put in place following the recertification survey of 7/1/21The deficiencies were in the areas of: accuracy of assessments, activity of daily living care provided to dependent residents, treatments/service to prevent/heal pressure ulcers and drug regimen is free from unnecessary drugs. This tag is cross referenced to: F641 -Facility failed to accurately code the Minimum Data Set (MDS)assessments in the areas of medications (Residents #22,#4 &#1) accidents (Resident #4 &#26) diagnoses (Resident #4) and urinary status (Resident #54) for 5 of 20 sampled residents whose MDS were reviewed. F644- Facility failed to refer a resident with newly evident diagnosis of mental health for Preadmission Screening and Resident Review (PASARR) level 2 screen for 1 of 1 sampled resident reviewed for PASARR (Resident #7) F686-Facility failed to obtain an order for treatment to the left buttock resident #4 and failed to ensure the air mattress was functioning resulting in a deflated air mattress resident #29 for 2of 3 sampled residents viewed for pressure ulcers #4	

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F 867	Continued From page 52 her activities of daily living (ADLs). This was for 1 of 1 resident reviewed for nail care. In an interview with the Administrator on 3/9/23 at 9:00 AM, she indicated the facility was utilizing agency staff and felt there was a lack of oversight and education to ensure showers were offered, provided, and documented that they were given or refused by the resident. 3. F686- Based on record review, observation, and interviews with the Physician, Wound Physician and staff, the facility failed to obtain an order for treatment to the left buttock pressure ulcer (Resident #4) and failed to ensure the alternating air mattress was functioning resulting in a deflated air mattress (Resident #29) for 2 of 3 sampled residents reviewed for pressure ulcers. During the facility's recertification survey of 7/1/21, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 2 of 4 residents reviewed for pressure ulcer. In an interview with the Administrator on 3/9/23 at 9:00 AM, she stated it was felt to be related to human error not to have documented when a treatment was completed as ordered. 4. F757- Based on record reviews, Nurse Practitioner, Medical Director and staff interviews, the facility failed to hold diabetic medications (Residents #18 and #42) and blood pressure medications (Residents #42 and #22) as ordered by the physician for 3 of 6 residents whose medications were reviewed. During the facility's recertification survey of	F 867	and #29. F757-Facility failed to hold diabetic medications (Residents #18 and #42) and blood pressure medications (Residents #42 and #22) as ordered by the physician for 3 of 6 residents whose medications were reviewed. On 3/10/2023, The Quality Assurance Nurse in serviced the Administrator in reference to the Quality Assessment and Assurance. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:(i) The director of nursing services;(ii) The Medical Director or his/her designee;(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The quality assessment and assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	

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F 867	Continued From page 53 7/1/21, the facility failed to hold the blood pressure medications as ordered and failed to check the blood pressure prior to administering the blood pressure medications for 2 of 5 sampled residents reviewed for unnecessary medications. In an interview with the Administrator on 3/9/23 at 9:00 AM, she indicated the facility was utilizing agency staff and felt the repeat citation could be a result of the need for education and oversight.	F 867	Effective 3/10/2023, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; To ensure compliance, Administrator or Director of Nursing will monitor this issue using a quality assurance (QA) survey tool. Facility will monitor compliance of QA for F641, F677, F686, and F757. This will be done on weekly basis for 4 weeks then monthly for 3 months by Administrator and reviewed monthly by the Quality Assurance Nurse Consultant to ensure compliance. Reports will be presented to the weekly QA Committee by the Administrator or Director of Nursing to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	**3100 TRAMWAY ROAD SANFORD, NC 27330**

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F 867	Continued From page 54	F 867	The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 4/15/2023	