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	345184	A. BUILDING _____ B. WING _____	C 03/02/2023

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CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/27/23 through 3/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #R1NC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/27/23 through 3/2/23. Event ID# R1NC11. The following intakes were investigated: NC00190548, NC00192453 , NC00194877 , NC00192195 , NC00191192, NC00192968, NC00190696, and NC00198313. 6 of the 19 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/30/23

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

Electronically Signed | 03/24/2023

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide a clean and sanitary environment by failing to clean a tube feeding pump and pole for 1 of 1 resident observed with a tube feeding pump and pole. (Resident #34) The facility also failed to provide a safe and sanitary environment when food and other debris was found lodged in 1 of 1 resident ' s HVAC (system used to heal and cool an area) unit. (Resident #15) The findings included: 1.On 2/27/23 at 11:51 AM Resident #34 was observed lying in bed and a pole with a tube feeding pump and a bag of milky tan tube feeding formula was connected to Resident #34 and	F 584	1. Resident #34's tube feeding pump and pole were cleaned and, then the pole replaced on 3/2/2023. Resident #15's HVAC unit was cleaned on 2/28/2023. 2. All tube feeding pumps and poles were audited during the period 3/16/2023 – 3/22/2023 to ensure all were clean, with adjustments were made as necessary. All HVAC units were inspected for cleanliness during the period 3/16/2023 – 3/22/2023, with adjustments made as necessary. 3. The administrator (NHA) in-serviced the Maintenance Director, Housekeeping & Laundry Director and the Food Service Director on cleanliness and sanitation expectations on March 20, 2023. The NHA also reviewed inspection, cleaning	

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F 584	Continued From page 2 infusing near the head of the resident ' s bed. The four legs of the pole were observed to have a milky tan substance on all four legs of the pole. The bottom of the tube feeding pump was observed to have a tan substance on the bottom of the pump. On 3/1/23 at 9:08 AM a second observation was conducted of the tube feeding pump and pole. There was a dried milky tan substance on all four legs of the pole and multiple dried spots of a milky tan substance were observed on the bottom of the feeding pump. An interview was conducted with Nurse #1 on 3/1/23 at 1:44 PM. Nurse #1 stated that housekeeping was responsible for cleaning the tube feeding pump and poles. On 3/1/23 at 2:13 PM an observation and interview were conducted with the Director of Nursing (DON). The DON confirmed there was a dried milky tan substance at the bottom of the pump and on the four legs of the pole. The DON stated it was the nurse caring for the resident ' s responsibility to clean the feeding pump and pole. 2.On 2/27/23 at 10:2 AM an observation of room 309 Bed B revealed 4- 5 quarter size light brown dried food particles to the left inside wall HVAC unit and multiple wads of paper and multiple unidentified raisin to dime size dried food particles inside the vents. On 2/28/23 at 2:15 PM an observation of room	F 584	and maintenance schedules for all three departments to ensure all items are present on these schedules and are being maintained in accordance with established calibration standards. 4. The Maintenance Director, or designee, will inspect 5 resident rooms weekly for the next 12 weeks. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for review and, if warranted, further action.	

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F 584	Continued From page 3 309 Bed B revealed 4- 5 quarter size light brown dried food particles to the left inside vents of the HVAC unit and multiple wads of paper and multiple unidentified raisins to dime size dried food particles inside the vents. On 2/28/23 at 2:45 PM an observation of room 309 Bed B's HVAC unit was conducted with the Director of Nursing and the appearance was unchanged from 2/28/23 at 2:15 PM. An interview on 2/28/23 at 2:46 PM the Director of Nursing (DON) indicated she would have staff clean the HVAC unit immediately. An interview on 3/2/23 at 5:02 PM the Administrator revealed she would have the maintenance man begin doing monthly rounds and clean any HVAC units as needed.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for 2 of 2 residents in the areas of pressure ulcer (Resident # 59) and mechanically altered diet (Resident #14). The findings included: 1.Resident #59 was admitted to the facility on	F 641	1. Resident #59's Minimum Data Set (MDS) and Care plan were updated to reflect the existence of a pressure sore, on 3/20/2023. Resident 14's MDS was updated to correctly reflect a mechanical soft diet on 3/2/2023. 2. Facility licensed staff audited residents with wounds and residents with mechanical soft diet orders to ensure that their MDS assessment and care plans accurately reflected their wounds and	3/30/23

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F 641	Continued From page 4 1/23/23 with diagnoses that included femur fracture. Review of the admission assessment dated 1/23/23 revealed Resident #59 had a surgical wound and no other skin impairment. A review of the Minimum Data Set (MDS) Assessment dated 1/30/23 revealed Resident #59 had severe cognitive impairment. Resident #59 was coded as having one Stage 3 pressure ulcer that was present on admission. Review of a nursing note dated 2/17/23 revealed Resident #59 had a new skin breakdown to her right buttocks. An interview was conducted with the MDS nurse on 3/2/23 at 3:39 PM. The MDS nurse stated she had coded Resident #59 with a pressure ulcer on the Admission MDS. The MDS nurse stated she got the information from the nurses notes and resident assessment. The MDS nurse indicated the pressure ulcer was discovered after the admission MDS. 2. Resident #14 was admitted to the facility on 6/04/20 with diagnoses that included dysphagia (difficulty swallowing). Resident #14's care plan last reviewed 9/27/22 revealed a care plan for nutritional risk with an intervention of diet as ordered. A physician order dated 10/24/22 for Regular diet, mechanical soft texture, regular/thin liquids	F 641	mechanical soft diet orders, the audit is being conducted during the period 3/23/2023 to 3/29/2023, and adjustments made as necessary. 3. The Interdisciplinary Care Plan team (IDCPT) members were in service on assessment and care plan accuracy during the period 3/23/2023 to 3/27/2023 by the Director of Nursing (DON) or designee. 4. The Director of Nursing (DON), or designee, will audit 5 MDS's and care plans weekly for 12 weeks to ensure that they accurately reflect the residents wound and diet status. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action.	

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F 641	Continued From page 5 consistency. The Minimum Data Set (MDS) Quarterly Assessment dated 12/03/22 revealed Resident #14 had severe cognitive impairment and was not coded for a mechanical soft texture diet. The MDS Nurse was interviewed on 3/02/23 at 1:02 pm. The MDS Nurse reviewed Resident #14's physician orders and confirmed a mechanical soft texture diet was in place. She stated the MDS assessment was incorrect and the mechanically textured diet should have been coded for Resident #14. An interview on 3/02/23 at 5:01 pm with the Administrator who revealed the MDS Nurse was responsible to accurately code Resident #14's mechanically altered diet.	F 641		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		3/30/23

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F 655	Continued From page 6 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission to address the immediate needs for 2 of 2 residents reviewed for new admission. (Resident #18, Resident #170) The findings included: 1.Resident #18 was admitted to the facility on 2/1/23 with diagnoses that included end stage	F 655	1. Baseline Care plans for Resident #18 and #170 were established on 3/2/2023. 2. Licensed Staff audited all residents who admitted in the last 30 days to ensure that they have a baseline care plan in place that accurately addresses the residents needs. This audit was conducted during the period 3/23/2023 – 3/27/2023, with adjustments made as necessary. 3. The Interdisciplinary Care Plan team	

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F 655	Continued From page 7 renal disease and type 2 diabetes mellitus. Review of the medical record revealed Resident #18 had a baseline care plan dated 2/6/23. A review of the Minimum Data Set (MDS) Assessment dated 2/8/23 revealed Resident #48 was cognitively intact and on dialysis. An interview was conducted with the Director of Nursing (DON) on 3/2/23 at 12:02 PM. The DON stated it was the receiving nurse ' s responsibility to initiate the baseline care plan within 48 hours to meet the resident ' s immediate needs. 2.Resident #170 was admitted to the facility on 2/20/23 with diagnoses that included pressure ulcer and type 2 diabetes mellitus with foot ulcer. Review of the medical record revealed no baseline care plan for Resident #170. A review of the Minimum Data Set (MDS) Assessment dated 2/27/23 revealed Resident #48 was cognitively intact and totally dependent on staff for activities of daily living (ADLS). Resident #170 was coded as having an unhealed stage 4 pressure ulcer, an unstageable wound, and a surgical wound. Resident # 170. An interview was conducted with the Director of Nursing (DON) on 3/2/23 at 12:02 PM. The DON stated it was the receiving nurse ' s responsibility to initiate the baseline care plan within 48 hours to meet the resident ' s immediate needs.	F 655	(IDCPT) members were in service on assessment and care plan accuracy during the period 3/23/2026 – 3/2/2023 by the DON. The DON, or designee, in serviced licensed and registered staff on admissions assessments during the period 3/23/2023 – 3/27/2023. 4. The DON, or designee, will audit 2 new admission charts per week for 12 weeks to ensure that the residents baseline care plan has been completed and addresses immediate needs. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/30/23

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F 656	Continued From page 8	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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F 656	Continued From page 9 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to develop an individualized person-centered care plan for 3 of 32 residents whose care plans were reviewed. (Resident #48, Resident #36, Resident #14) The findings included: 1.Resident #48 was admitted to the facility on 1/27/23 and had a diagnosis of malignant neoplasm of the esophagus. Review of a physician order dated 1/27/23 revealed an order for Hydrocodone-Acetaminophen Oral tablet 5-325 mg (milligram) - Give 0.5 tablet via G-tube (a surgically placed device used to give direct access to the stomach) every six hours as needed for pain. The most recent Minimum Data Set (MDS) Assessment dated 2/16/23 revealed Resident #48 was cognitively intact. The MDS indicated Resident #48 had received opioid pain medication 5 days of the look back period. A review of Resident #48 ' s active care plan dated 2/16/23 did not reveal a care plan for pain management. On 3/2/23 at 3:44 PM the MDS nurse stated	F 656	1. Resident #48's care plan was updated to include pain management on 3/2/2023. Resident #36's care plan was updated to include respiratory care on 3/2/2023. Resident #14's care plan was updated on 3/2/2023 to include a plan for antipsychotic medication. 2. Licensed Staff audited the residents who have orders for pain medication/ pain management care, the residents who have orders for oxygen/ respiratory care and residents who have orders for Antipsychotic medications to ensure that the residents care plans accurately reflects the orders. The audit is being conducted during the period of 3/23/2023 – 3/29/2023, with adjustments made as necessary. 3. The Interdisciplinary Care Plan team (IDCPT) members were in serviced on assessment and care plan accuracy during the period 3/23/2026 – 3/28/2023 by the DON. The DON, or designee, in service licensed and registered staff on admissions assessments during the period 3/23/2023-3/28/2023. 4. The DON, or designee will audit 5 residents per week for the next 12 weeks of residents who have orders for pain medication/ pain management care, the residents who have orders for oxygen/	

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F 656	Continued From page 10 Resident #48 should have been care planned for pain due to his diagnosis of malignant neoplasm of the esophagus. An interview was conducted with the Director of Nursing on 3/2/23 at 3:49 PM. The DON stated that the care plan should have been updated to reflect Resident #48 ' s current status. 2.Resident #36 was admitted to the facility on 4/17/21 and had a diagnosis of chronic obstructive pulmonary disease. Review of physician ' s order dated 10/12/22 revealed an order for oxygen 2 liters via nasal cannula as needed. The most recent Minimum Data Set (MDS) dated 12/17/22 revealed Resident #36 was cognitively intact and on oxygen therapy. A review of Resident #36 ' s active care plan dated 12/17/22 did not reveal a care plan for respiratory care. An interview was conducted with the MDS Nurse on 3/2/23 at 3:46 PM. The MDS nurse reviewed Resident #36 ' s current care plan and indicated the resident should have had a respiratory care plan. The MDS nurse stated she pulled her information from the nursing notes and resident assessment. The MDS nurse stated she had not been attending the daily clinical meeting and realized that she was missing pertinent resident information. An interview was conducted with the Director of	F 656	respiratory care and residents who have orders for Antipsychotic medications to ensure that the residents care plans accurately reflects the orders. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action.	

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F 656	Continued From page 11	F 656		

Nursing on 3/2/23 at 3:49 PM. The DON stated that the care plan should have been updated to reflect Resident #36 ' s current status.

3. Resident #14 was admitted to the facility on 6/04/20 with a diagnosis of dementia.

A physician order dated 7/23/22 for Seroquel (antipsychotic medication) 25 milligram (mg) for vascular dementia with behaviors.

The Minimum Data Set (MDS) Quarterly Assessment dated 12/03/22 revealed Resident #14 had severe cognitive impairment, he did not have any behaviors, and received antipsychotic medication.

Record review of Resident #14's care plan last revised on 9/27/22 revealed no care plan for antipsychotic medication.

During an interview on 3/02/23 at 1:02 pm the MDS Nurse revealed a care plan was required for Resident #14's Seroquel medication which would include information about the medication, monitoring for behaviors, and signs and symptoms of an adverse reactions. The MDS Nurse stated she was responsible to review and update Resident #14's care plan but she stated she was new to the facility and had not yet reviewed his care plan.

During an interview on 3/02/23 at 2:14 pm the Director of Nursing (DON) revealed the MDS Nurse was responsible to ensure Resident #14's care plan was accurate. The DON was unable to state why Resident #14's care plan was not in place for the antipsychotic medication as required

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F 656	Continued From page 12 because she was new to the facility. An interview was conducted on 3/02/23 at 5:01 pm with the Administrator, who revealed the care plan was reviewed and updated as needed at the weekly risk meeting with the DON and MDS Nurse. The Administrator stated she was new to the facility and was unable to state why Resident #14's care plan for antipsychotic medication was not implemented when the order was obtained.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide hair washing for 1 of 3 residents (Resident #43) reviewed for Activity of Daily Living (ADL) care who required assistance with bathing. The findings included: Resident #43 was admitted to the facility on 3/19/21 and most recently readmitted on 1/17/23 with diagnoses that included osteoarthritis, coronary artery disease, and congestive heart failure. Review of the most recent Minimum Data Set dated 1/25/23 revealed Resident #43 was cognitively intact. She had no behaviors or rejection of care. She required total assistance, one-person physical assistance with bathing.	F 677	1. Resident #43 was provided hair care on 3/1/2023. 2. Nursing Staff audited all residents on 3/23/2023 -3/27/2023 to ensure proper hair care was being delivered. 3. The DON inserviced Licensed and certified staff on providing personal hygiene care during the period 3/23/2023 – 3/28/2026 on providing personal hygiene care. 4. The DON, or designee, will audit for proper resident personal hygiene 5 residents per week for the next 12 weeks. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action.	3/30/23

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F 677	Continued From page 13	F 677		

An observation on 2/27/23 at 11:08 AM revealed Resident #43's hair appeared to be greasy, tangled and matted.

During an interview on 2/28/23 at 8:33 AM Resident #43 stated she would like her hair washed and the matted hair on the back of her head addressed. She stated that the staff had not washed her hair in a long time and only partially brushed her hair due to her tangles and mats.

An observation on 3/1/23 at 8:55 AM Resident #43's hair appeared to be in an unchanged condition from 2/28/23.

On 03/01/23 at 2:12 PM Resident #43 was observed sitting in the Resident Council Meeting. The resident was observed with her hair up in a pony tail and in an unchanged condition.

An interview on 3/1/23 at 2:21 PM Nurse Aide (NA) #1 revealed after the resident returned from a hospital stay in January, and she had used a soap less shower cap 3 times to wash her hair. NA #1 stated that she did not know when the resident's hair was last washed.

An interview on 3/1/23 at 4:24 PM the Director of Nursing (DON) revealed they had previously used soap less shower caps to wash Resident's #43 hair. The DON indicated they would wash and comb her hair and if needed comb out any tangles in her hair.

On 03/02/23 at 9:30 AM Resident #43 was observed with her hair clean and neatly trimmed. The resident stated staff could not detangle her hair and had to cut out the matted parts. She

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F 677	Continued From page 14 indicated she was pleased with her shorter hair.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Nurse Practitioner, and Medical Director interviews the facility failed to follow physician orders for turning and repositioning and failed to monitor specialty air mattress settings to ensure set to correct weight for 1 of 6 residents reviewed for pressure ulcers (Resident #42). Findings included: Record review of the hospital Discharge Summary dated 1/06/23 revealed Resident #42 had a large right ischium (buttock/hip area) pressure ulcer and a large sacral pressure ulcer. Resident #42 was admitted to the facility on 1/06/23 with diagnoses which included dementia, protein calorie malnutrition, and pressure ulcers	F 686	1. Resident #42's care plan and care guide (Bedside Kardex Report) was reviewed on 3/2/2023 by administrative nursing staff and adjustments made as necessary and the residents air mattress was set to the correct weight. 2. Administrative Nursing Staff audited care plans for all residents who present with wounds for accuracy with respect to wound treatment protocols and appropriate air mattress settings during the period 3/23/2023 – 3/28/2023. 3. The DON inserviced all licensed and certified staff during the period 3/23/2023 – 3/28/2023 on adherence to the care plan in accordance with the doctor's orders, including turning schedules. 4. The DON, or designee will audit 4	3/30/23

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F 686	Continued From page 15 to sacrum and right ischium. The care plan dated 1/06/23 and last updated 1/19/23 revealed Resident #42 had multiple pressure ulcers and potential for new pressure ulcer development related to immobility with interventions which included turn and reposition at least every 2 hours by staff and a pressure relieving air mattress on bed. The admission Minimum Data Set (MDS) Assessment dated 1/11/23 revealed Resident #42 had severe cognitive impairment. She was dependent upon two staff members for bed mobility and was not coded for rejection of care. Resident #42 had a stage 3 pressure ulcer to sacrum and a stage 3 pressure ulcer to right ischium, a pressure reducing device on bed, nutrition, or hydration interventions to manage skin problems, and received pressure ulcer care. A physician order dated 1/16/23 to turn and reposition resident every 2 hours. A physician order dated 2/17/23 for specialty air mattress related to wounds. Check functioning and settings each shift. Pressure is set to weight. Resident #42's weight on 2/27/23 was 108 pounds. Record review of the Bedside Kardex Report (care guide), no date, revealed Resident #42 needed staff to turn/reposition at least every 2 hours, more often as needed or requested. An observation on 2/28/23 at 8:35 am Resident #42 was positioned on her left side with pillows behind her back. The air mattress was set at	F 686	residents with wounds per week for the next 12 weeks for adherence to the Specialty mattress order and turn and position order. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action	

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F 686	Continued From page 16	F 686		

approximately 85-90 pounds.

Further observations on 2/28/23 at 9:11 am, 10:45 am, 12:30 pm, and 2:40 pm Resident #42 was positioned on her left side with pillows behind her back. The air mattress was observed to be set at approximately 85-90 pounds.

An interview was conducted on 2/28/23 at 2:42 pm with Nurse Aide (NA) #1, who was assigned to Resident #42 during the 7:00 am-3:00 pm shift, revealed she had worked most of the shift by herself and had not been able to provide the level of care needed due to not having help. She stated she did not turn Resident #42 as ordered and could not remember if she repositioned her during the shift.

An observation on 3/01/23 at 9:06 am Resident #42 was positioned on her back. The air mattress was set at 80 pounds.

An observation on 3/01/23 at 11:07 am Resident #42 was positioned on her back. The air mattress was set at 80 pounds.

An observation on 3/01/23 at 11:50 am and 1: 15 pm Resident #42 was positioned on her back and the air mattress was set at 80 pounds.

During an interview on 3/01/23 at 2:27 pm NA #2, who was assigned to Resident #42 from 7:00 am-3:00 pm, revealed she did not turn Resident #42 often because she looked comfortable on her back. NA #2 reported she did turn and reposition Resident #42 but was unable to remember what time or how often she turned and repositioned her during her shift.

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F 686	Continued From page 17	F 686		

An interview was conducted on 3/01/23 at 3:52 pm with Nurse #3, who was assigned to Resident #42 during the 7:00 am-3:00 pm shift, revealed she turned and repositioned Resident #42 one time today but could not recall what time. She stated she moved her back onto her back, and she appeared comfortable in that position. Nurse #3 was not aware of the incorrect setting on the air mattress because she does not monitor the air mattress setting.

During an interview on 3/01/23 at 3:25 pm the Treatment Nurse revealed she was responsible to monitor and ensure the air mattress was on the correct setting based on Resident #42's weight. She stated she obtained Resident #42's weight from the weekly weight report and documented the weight on her treatment card that was on the treatment cart. The Treatment Nurse stated she checked the air mattress when she completed Resident #42's treatment daily but stated had not noticed the air mattress was not set on the correct weight this week. The Treatment Nurse confirmed the air mattress was set to 80 pounds but was unable to state when the setting was changed and who changed it.

During an interview on 3/01/23 at 3:30 pm the Assistant Director of Nursing (ADON) who was present in Resident #42's room during the Treatment Nurse interview, confirmed the air mattress was not set to Resident #42's current weight but was unable to state why the air mattress was not set to the correct setting.

During an interview on 3/02/23 at 11:15 am the Nurse Practitioner (NP) revealed Resident #42 was at risk for further pressure injury if she was not turned and repositioned and when the air

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F 686	Continued From page 18 mattress was not set to the correct setting. An interview on 3/02/23 at 2:34 pm with the Director of Nursing (DON) revealed the Treatment Nurse was responsible for ensuring the air mattress setting was correct. The DON reported the staff was to turn and reposition Resident #42 as ordered. A telephone interview was conducted with the Medical Director on 3/02/23 at 4:26 pm revealed the air mattress not being set at the correct setting and the turning and repositioning not being completed increased Resident #42's risk for worsening of the pressure ulcers or formation of new skin concerns. During an interview on 3/02/23 at 5:09 pm the Administrator revealed the nursing staff was expected to follow physician orders as written for Resident #42.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		3/30/23

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F 688	Continued From page 19 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to place hand/wrist splint to the left hand for contracture management for 1 of 4 residents reviewed for limited range of motion (Resident #2). Findings included: Resident #2 was admitted to the facility on 10/16/19 with diagnoses which included cerebral palsy and abnormal posture. The Minimum Data Set (MDS) Quarterly Assessment dated 2/03/23 revealed Resident #2 had moderately impaired cognition, had limited range of motion (ROM) of the upper and lower extremities, and was totally dependent on staff members for bed mobility and transfers. Resident #2 was not coded for behaviors. A physician order dated 2/07/23 for Resident #2 to wear her left upper extremity (LUE) hand/wrist orthosis during 7-3 shift. The resident was also able to remove the orthosis herself. Resident #2's care plan last revised on 2/17/23 revealed a care plan for the left resting hand splint to be applied during AM dressing. A care plan for potential pressure ulcer development related to LUE contracture with intervention to check skin integrity and apply left hand splint in morning.	F 688	1. Nursing Staff audited Resident #2 care plan and Kardex on 3/2/2023 and made adjustments as necessary. Licensed staff applied the wrist/hand splint in accordance with physician orders on 3/2/2023. 2. Administrative nursing staff audited all residents with adaptive equipment or devices during the period 3/23-2023 – 3/28/2023 for care plan accuracy and delivery of care, with adjustments made as necessary. 3. The DON inserviced all licensed and certified staff in delivering care in accordance with the care plan and Kardex during the period 3/23-2023 – 3/28/2023. 4. The DON, or designee, will complete a weekly audit fore the next 12 weeks of the residents who have contracture management splints to ensure that the order is being followed. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action.	

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F 688	Continued From page 20	F 688		

Record review of the Bedside Kardex (care guide) Report (no date) revealed Resident #2's splint was not listed to be placed on her left hand during the 7:00 am -3:00 pm shift.

During an observation on 2/27/23 at 12:00 pm Resident #2 was sitting in her wheelchair without a splint on her left hand. The splint was observed on the back of the wheelchair hung from the push handle. Resident #2's left wrist was observed with flexion (bent at wrist) and her fingers pointed towards the forearm.

An observation on 2/28/23 at 10:38 am and 12:54 pm revealed Resident #2 was in bed without a splint on her left hand. The splint was observed to be on the back of the wheelchair hung from the push handle. Resident #2's left wrist was observed with flexion (bent at wrist) and her fingers pointed towards the forearm.

An interview on 2/28/23 at 12:55 pm Resident #2 stated staff had not put the splint on her hand. She denied pain to the left wrist. Resident #2 was able to confirm the splint hung on the push handle of the wheelchair was her splint.

During an interview on 2/28/23 at 1:27 pm the Rehabilitation Director revealed the rehabilitation department evaluated and determined a need for splinting for Resident #2's left hand contracture management. He stated once the need for splinting was determined the nursing staff was educated on how to use the splint and the order was entered for Resident #2. The Rehabilitation Director stated the nursing department was responsible to place the splint on Resident #2's left hand every day as ordered.

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F 688	Continued From page 21	F 688		

An interview was conducted on 2/28/23 at 4:19 pm with Nurse #4 who revealed Resident #2 did not have her splint on her left hand recently but had seen her wear it in the past. Nurse #4 stated she was unsure who was responsible to put the splint on and take it off, but she had not seen Resident #2 remove the splint herself when it was in place.

An observation on 3/01/23 at 1:08 pm revealed Resident #2 did not have the splint on her left hand. The splint was observed on the back of the wheelchair hung on the push handle. Resident #2's left wrist was observed with flexion (bent at wrist) and her fingers pointed towards the forearm.

During an interview on 3/01/23 at 2:24 pm Nurse Aide (NA) #2 revealed she did not know Resident #2 had a splint for her left hand. She stated she was unable to remember if she saw the splint in Resident #2's room.

During an interview on 3/02/23 at 2:20 pm the Director of Nursing (DON) revealed she was new to the facility and was not familiar with Resident #2's splint order but stated the nursing staff was responsible to ensure the splint was on Resident #2's left hand as ordered.

An interview was conducted on 3/02/23 at 5:05 pm with the Administrator who revealed she was new to the facility and was not able to state why Resident #2's splint was not in place when there was an order. She stated when the order was received the nursing staff was responsible to review the order, update the Bedside Kardex Report, and ensure front line staff was educated on how to apply the splint and when the splint

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F 688	Continued From page 22 was to be on Resident #2's left hand.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		3/30/23

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F 690	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and physician interviews, the facility failed to maintain an indwelling urinary catheter drainage bag below the bladder to allow for proper drainage and reduce risk for urinary tract infection (Resident #42) and failed to obtain a physician order for indwelling urinary catheter for 2 of 2 residents (Resident #42 and Resident #170) reviewed for urinary catheter. Findings include: 1. Resident #42 was admitted to the facility on 1/06/23 with diagnoses which included dementia and retention of urine. The Minimum Data Set (MDS) Admission Assessment dated 1/11/23 revealed Resident #42 had severe cognitive impairment, required assistance by 2 staff member for bed mobility, and was coded for an indwelling urinary catheter. Resident #42's care plan last revised on 1/19/23 revealed she had an indwelling urinary catheter due to urine retention with interventions which included to position the catheter bag and tubing below the level of the bladder and away from entrance room door. a. Record review of the physician orders revealed no order for Resident #42's indwelling urinary catheter. During an interview on 3/02/23 at 1:11 pm the MDS Nurse revealed she coded for an indwelling catheter and entered a care plan based on review the hospital discharge summary and an	F 690	1. Administrative nursing Staff obtained a physician's order for Resident #42 and correctly positioned Resident #42's catheter bag on 3/2/2023. Administrative nursing staff obtained an order for Resident 170's indwelling catheter on 3/2/2023. 2. Administrative nursing staff audited all other residents with indwelling catheters for adherence to physician orders and correct placement of the catheter bag during the period 3/23/2023 – 3/28/2023. 3. The DON and ADON in-serviced all licensed and certified staff during the period 3/23/2023 – 3/28/2023 on proper placement of the drainage bag for a urinary catheter. The DON in-serviced all the licensed nurses on obtaining a physician order for a resident with an indwelling urinary catheter. 4. The DON, or designee, will complete a weekly audit for the next 12 weeks of the residents with an indwelling urinary catheter to ensure that they have a physician order and that the placement of the urinary bag is appropriate. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action.	

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observation of Resident #42. The MDS Nurse stated she did not review the orders to confirm an order was in place for the indwelling catheter because she utilizes hospital record and observation to complete the care plan and MDS assessments.

A telephone interview on 3/02/23 at 1:30 pm with Nurse #2 revealed Resident #42 admitted to the facility with the indwelling urinary catheter. Nurse #2 stated when a resident admitted with an indwelling urinary catheter, she would continue the order and if there was not an order, she would call the doctor to continue or discontinue the indwelling urinary catheter. Nurse #2 was unable to state why she did not enter an order or call the physician for Resident #42's indwelling urinary catheter.

An interview was conducted on 3/02/23 at 2:24 pm with the Director of Nursing (DON) who revealed a physician order was required for Resident #42's indwelling urinary catheter. The DON was unable to state why the order was not obtained when Resident #42 was admitted with the urinary catheter.

During a telephone interview on 3/02/23 at 4:26 pm the Medical Director revealed an indwelling urinary catheter required a physician order. The Medical Director stated the order for Resident #42's indwelling urinary catheter should have been entered.

b. Observations on 2/27/23 at 10:59 am and 12:27 pm revealed Resident #42 was in bed with the indwelling urinary catheter drainage bag hung from the upper side rail of the left side of the bed positioned above the level of her bladder with

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urine in the drainage tube.

An observation on 2/28/23 at 9:23 am revealed Resident #42 was in bed and the indwelling urinary catheter drainage bag was hung from the upper side rail on the left side of the bed positioned above the level of her bladder and adjacent to her head with urine in the drainage tube.

During an interview on 2/28/23 at 10:30 am Nurse Aide (NA) #1 revealed the catheter drainage bag was supposed to be hung from the lower part of the bed. NA #1 denied she placed the urinary catheter bag on the upper side rail and had not noticed it on the side rail.

During an interview on 3/02/23 at 2:24 pm the Director of Nursing (DON) revealed Resident #42's indwelling urinary catheter drainage bag was to be hung on the lower portion of her bed to allow for urine to drain into the bag.

A telephone interview was conducted on 3/02/23 at 4:26 pm with the Medical Director who revealed Resident #42's indwelling urinary catheter drainage bag hung above the level of the bladder was problematic. He stated when the drainage bag was placed above the level of the bladder the urine was not able to freely drain and could cause reflux (urine to flow back into bladder) and increased potential for urinary tract infections for Resident #42.

An interview on 3/02/23 at 5:13 pm the Administrator revealed she was new to the facility but stated nursing was required to ensure that physician orders were in place to properly care for Resident #42's indwelling urinary catheter.

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F 690	Continued From page 26 2. Resident #170 was admitted to the facility on 2/20/23 with a diagnosis of chronic kidney disease. A review of the Minimum Data Set (MDS) Assessment dated 2/27/23 revealed Resident #170 was cognitively intact, was totally dependent on staff for activities of daily living (ADLs) and coded for an indwelling urinary catheter. Resident #170 ' s care plan dated 2/27/23 revealed he had an indwelling urinary catheter due to neurogenic bladder with interventions that included change catheter per physician ' s order and resident has an 18 French indwelling urinary catheter. A review of the physician ' s orders did not reveal an order for Resident #170 ' s indwelling urinary catheter. An interview was conducted with the MDS nurse on 3/2/23 at 3:39 PM. The MDS nurse stated she developed the care plan using information from the hospital discharge summary and observation. The MDS Nurse stated she did not review the physician ' s orders to confirm if there was an order for urinary indwelling catheter. An interview was conducted with the Director of Nursing (DON) on 3/2/23 at 4:12 PM. The DON stated an order was required for Resident #170 ' s urinary catheter. She was unable to state why the order was not obtained when Resident #170 was admitted.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		3/30/23

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F 697	Continued From page 27 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to follow physician ' s order to administer as needed pain medication to control a resident ' s pain for 1 of 1 residents reviewed for pain management. (Resident #48) The findings included: Resident #48 was admitted to the facility on 1/27/23 and had a diagnosis of malignant neoplasm of the esophagus and Stage 4 pressure ulcer. The most recent Minimum Data Set (MDS) Assessment dated 2/16/23 revealed Resident #48 was cognitively intact. The MDS indicated Resident #48 had received opioid pain medication 5 days of the look back period. Review of the physician ' s orders revealed an order with a start date of 1/27/23 that read as follows: "Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams)-Give 0.5 tablet via G-Tube every 6 hours as needed for pain." Hydrocodone is a narcotic medication used to treat moderate to severe pain. An observation and interview were conducted of Resident #48 on 3/2/23 at 1:45 PM. Resident #48 was grimacing and verbalized pain. Resident #48 rated his pain at 8 on a scale of 10. He stated he	F 697	1. Resident #48 was administered prn pain medication by licensed staff on 3/1/2023 in accordance with the doctor's orders. 2. All other residents with orders for prn pain medication were reviewed to ensure compliance. 3. The DON and ADON in-serviced all licensed staff on ensuring accuracy in delivering prn medication in accordance with the physician's orders. 4. The DON, or designee, will audit 5 residents per week for the next 12 weeks of residents who have pain medication orders to ensure that the physician order is being followed for appropriate pain management . Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for 12 months for review and, if warranted, further action	

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F 697	Continued From page 28 had asked the nurse for something for pain. Resident #48 stated that staff usually gave him Hydrocodone if he was in a lot of pain. An interview was conducted with Nurse #1 on 3/2/23 at 1:49 PM. Nurse #1 stated that Resident #48 could only have Tylenol to treat his pain and the resident did not want that. An interview was conducted with the Director of Nursing (DON) on 3/2/23 at 2:00 PM. The DON reviewed Resident #48 ' s physician ' s orders and verified there was an order for Hydrocodone. The DON stated Nurse #1 should have administered Hydrocodone to Resident #48 to treat his pain. The DON further stated any time a resident complains of unrelieved pain the nurse caring for that resident should notify the physician.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to document an assessment of the resident ' s status, shunt cite, and vital signs upon returning to the facility after dialysis for 1 of 2 residents reviewed for dialysis. (Resident #18). The findings included:	F 698	1. Administrative nursing staff amended Resident 18's care plan to include dialysis access care on 3/2/2023. Licensed nursing staff provided dialysis access care to Resident #18 on 3/1/2023. 2. Administrative nursing staff audited all other residents on dialysis to ensure dialysis access care is included on their	3/30/23

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F 698	Continued From page 29 Resident #18 was admitted to the facility on 2/1/23 with diagnoses of end stage renal disease and dependence on renal dialysis. Review of the physician ' s orders with a start date of 2/1/23 read in part the following: "Dialysis, Monday, Wednesday, Friday." The Admission Minimum Data Set (MDS) dated 2/8/23 revealed Resident #18 was cognitively intact. The MDS noted Resident #18 received dialysis while residing in the facility. Further review of the medical record revealed there were no orders for dialysis access care. An interview was conducted with Resident #18 on 2/28/23 at 3:39 PM. Resident #18 stated that the nurses did not consistently look at his dialysis shunt site when he returned from dialysis. Resident #18 stated he had not had any bleeding from the shunt site, and he removed the dressing the next day. An interview was conducted with the Assistant Director of Nursing (ADON) on 3/2/23 at 2:47 PM who was caring for Resident #18. The ADON stated that dialysis residents are checked prior to going to dialysis and the dialysis shunt is assessed when the resident returns to the facility for bleeding. An interview was conducted with the Medical Director on 03/02/23 at 04:35 PM. The Medical Director revealed that the standard care of practice would indicate that orders should be in place to monitor the dialysis assess site.	F 698	care plan during the period 3/23/2023 – 3/28/2023. 3. The DON and ADON in-serviced all licensed staff on ensuring accuracy in assessing dialysis access care in accordance with the physician's orders and facility policy. 4. The DON, or designee, will audit the residents on dialysis weekly for the next 12to ensure that accurate documentation of the residents status, shunt cite and vitals signs are obtained. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action.	

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F 698	Continued From page 30 An interview was conducted with the Director of Nursing on 3/2/23 at 4:54 PM. The DON stated that the admitting nurse was responsible for entering the dialysis access care order. She was unable to say why the order was not entered at admission.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		3/30/23

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F 758	Continued From page 31 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Physician interview, and Pharmacy Consultant interview, the facility failed to ensure Physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #5). Findings included: Resident #5 was admitted to the facility on 12/10/14 with diagnoses which included schizophrenia, bipolar disorder, and anxiety. The Minimum Data Set (MDS) Quarterly Assessment dated 12/10/22 revealed Resident #5 was cognitively intact. She was coded as having behaviors which included rejection of care and yelling at others. Resident #5 was coded for antipsychotic and antianxiety medication use	F 758	1. Administrative nursing staff completed a Stop Order for Resident #5's prn antipsychotic medication on 3/3/2023. 2. Administrative nursing staff audited all residents with PRN antipsychotic medication orders for to ensure that they have an end date within the limited 14 day time frame. 3. The DON or designee in-serviced the IDCPT, and the licensed staff on appropriate orders, including dispensing, for antipsychotic medications to ensure such medications are time-limited to NLT 14 days. 4. The DON, or designee, will audit residents with prn antipsychotic medications weekly for 12 weeks. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI)	

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F 758	Continued From page 32 during the lookback period. A physician order dated 1/27/23 for Diazepam (anxiety medication) 5 milligram (mg) tablet every 12 hours as needed for anxiety was ordered without a stop date. Record review of the January 2023 Medication Administration Record (MAR) revealed Resident #5 was administered the PRN Diazepam on 1/28/23. Record review of the February 2023 MAR revealed Resident #5 was administered the PRN Diazepam on 2/01/23, 2/10/23, 2/11/23, and 2/14/23. An interview was conducted on 3/02/23 at 1:34 pm with Nurse #2 who revealed she entered the PRN Diazepam order as it was told to her. She stated she did not know to enter a stop date and she was unable to remember who she obtained Resident #5's PRN order from. A telephone interview was conducted on 3/02/23 at 11:25 am with the Pharmacy Consultant who revealed she sent the pharmacy recommendation to the facility for the Diazepam order that required a stop date from her review completed on 2/18/23. The Pharmacy Consultant stated the recommendation noted the discontinuation of the medication or if still needed to add a stop date for Resident #5's PRN Diazepam. During an interview on 3/02/23 at 12:01 pm the Director of Nursing (DON) revealed the Diazepam PRN order was required to have a stop date. She stated she did receive the Pharmacy Consultant recommendation previously but was	F 758	Committee for review and, if warranted, further action.	

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F 758	Continued From page 33 able to locate it today. The DON stated she has been at the facility for 4 weeks and had not had the opportunity to review psychotropic medication orders yet to check for missing stop dates on PRN orders. During a telephone interview on 3/02/23 at 4:26 pm the Medical Director revealed the Diazepam PRN order required a stop date. He stated he typically wrote the order with a stop date of 10-14 days and would reevaluate the need and order if needed. The Medical Director stated Resident #5 required the medication to manage her anxiety, but the PRN order required a stop date. During an interview on 3/02/23 at 4:58 pm the Administrator revealed new medication orders were to be reviewed in the morning clinical meeting to ensure the orders were entered correctly and follow-up at the risk meeting to ensure the monthly pharmacy recommendations were completed. The Administrator was unable to state why the Diazepam PRN order for Resident #5 did not have a stop date because she was new to the facility.	F 758		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide adaptive	F 810	1. Staff provided Resident #2 with appropriate adaptive equipment on	3/30/23

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F 810	Continued From page 34 eating utensils and equipment as ordered by the physician for 1 of 3 residents requiring adaptive equipment for meals (Resident #2). Findings included: Resident #2 was admitted to the facility on 10/16/19. A physician order dated 1/02/23 for regular diet, puree texture, thin liquids, resident uses personal sippy cups, continue built-up utensils, plate guard. The Minimum Data Set (MDS) Quarterly Assessment dated 2/03/23 revealed Resident #2 had moderately impaired cognition, had limited range of motion (ROM) of the upper and lower extremities, and required setup help only for eating. An observation on 2/27/23 at 12:33 pm Resident #2 was observed to have no built-up utensils or plate guard on meal tray. No built-up utensils or plate guard were observed in the resident's room. Review of Resident #2's printed dietary meal ticket on 2/28/23 revealed two handle cup on tray, built-up utensils, and plate guard. An observation on 2/28/23 at 9:20 am revealed Resident #2 did not have built-up utensils or plate guard on meal tray. Resident #2 was observed to have puree texture diet pushed off the plate into the space between the plate and plate warmer base. No built-up utensils or plate guard were observed in the resident's room. An observation on 2/28/23 at 12:53 pm revealed no built-up utensils or plate guard on Resident	F 810	3/2/2023. 2. Administrative nursing staff audited care plans of all other residents with orders for adaptive equipment during the period 3/23/2023 – 3/28/2023. 3. The facility list of residents, and their specific items of adaptive equipment, will be maintained by the rehab director and will be updated daily at the morning clinical meeting prn. 4. To ensure accuracy of delivery of care, The DON, or designee, will complete a weekly audit for the next 12 weeks of residents who have an order for adaptive eating equipment to ensure that the order is being followed and that the resident is provided the appropriate equipment. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action.	

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F 810	Continued From page 35	F 810		

#2's meal tray. No built-up utensils or plate guard were observed in the resident's room.

An interview on 2/28/23 at 1:33 pm the Rehabilitation Director revealed Resident #2 had built-up utensils, but he was usure about the plate guard. He stated the built-up utensils were not ordered by the therapy department, but he stated the information was given to the dietary department for ordering.

During an interview on 2/28/23 at 1:47 pm Nurse Aide (NA) #1 revealed Resident #2 did not have the plate guard or built-up utensils on her breakfast or lunch meal trays. She stated she did not know about the built-up utensils or plate guard because she did not look at the meal ticket prior to meal setup for Resident #2.

An interview was conducted on 2/28/23 at 3:16 pm with the Dietary Manager who revealed Resident #2 was to receive the built-up utensils and plate guard for meals as listed on her meal ticket. The Dietary Manager stated the adaptive equipment had not been returned to the kitchen and the items could be in the resident room. The Dietary Manager was unable to state why she was not notified by line staff that the adaptive equipment for Resident #2's meal tray was not returned to the kitchen.

An interview was conducted with the Director of Nursing (DON) on 3/02/23 at 2:21 pm. The DON revealed the adaptive equipment, which included the built-up utensils and plate guard, were supplied by the dietary department. She stated the dietary department was to send the adaptive equipment from the kitchen on the meal trays as ordered.

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews the facility failed to maintain 1of 1 nourishment refrigerator in a clean and sanitary manner to prevent cross contamination by failing to clean up liquid spills. The findings included: On 2/28/23 at 2:15 PM an observation of the nourishment refrigerator revealed a clear liquid was pooled underneath the 2 clear drawers. When the empty drawer was pulled out, liquid sloshed out onto the refrigerator frame. On 3/1/23 at 9:35 AM an observation of the nourishment refrigerator revealed a clear liquid	F 812	The nourishment room refrigerator was cleaned by dietary staff on 3/1/2023. 2. On 3/16/2023 the dietary manager inspected all other dietary refrigeration equipment for compliance and made no further adjustments. 3. On 3/24/2023 the dietary manager in-serviced all dietary staff on cleanliness expectations and use of the nourishment room refrigerator. 4. The dietary manager, or designee, will audit the nourishment room refrigerator weekly for the next 12 weeks. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI)	3/30/23

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F 812	Continued From page 37 was pooled underneath the 2 clear drawers. When the empty drawer was pulled out, liquid sloshed out onto the refrigerator frame and floor. An interview on 3/1/23 at 10:39 AM the dietary manager revealed she would remind staff to check and completely wipe down the nourishment refrigerator. An interview on 3/2/23 at 4:55 PM the Administrator revealed dietary staff had defrosted and drained the nourishment refrigerator and would wipe it down.	F 812	Committee for review and, if warranted, further action.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		3/30/23

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F 867	Continued From page 38	F 867		

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 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.

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F 867	Continued From page 39 §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 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	F 867		

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F 867	Continued From page 40 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 review, staff, and the facility ' s Quality Assessment and Assurance (QAA) Committee, the facility failed to maintain implemented procedures and monitor interventions the committee put into place following the 7/14/20 complaint investigation survey, 9/20/20 complaint survey, 5/10/21 complaint survey, and the 3/30/22 recertification and complaint investigation and survey. This was for 5 deficiencies cited on the current recertification and complaint investigation survey of 3/2/23. A deficiency was cited on 3/30/22 in the area of safe/clean/ homelike environment (F584). A deficiency was cited on 9/20/20, 5/10/21, and 3/30/22 in the area of accuracy of assessments (F641). A deficiency was cited on 5/10/21 and 3/30/22 in the area of develop/implement comprehensive care plan (F656). A deficiency was cited on 7/14/20 in the area of bowel and bladder incontinence, catheter, urinary tract infection (F690). A deficiency was cited on 5/10/21 in the area of influenza pneumococcal immunizations (F883). The continued failure during two or more surveys of record shows a pattern of facility ' s inability to sustain an effective QAA committee. The findings included:	F 867	1. Root cause analysis for each of the 5 areas cited under this tag are due to a combination of a lack of training for key staff members, a lack of structure in following established policies and procedures, and a lack of accountability in executing those same established policies and procedures. In each case, specific instances of corrective action for residents cited will be found in the specific 4-step Plan of Correction for the corresponding F-Tag. 2. The NHA has reviewed IDCPT, MDS and administrative nursing duties, including established timeframes and parameters for the delivery of care. The NHA has established a formal QAPI calendar, with times and dates, for 2023-2024 and a formal meeting minutes format in which participants have been trained on metrics to report at each meeting and in identifying trends. Further, the NHA has established mandatory meetings for the IDCPT, including daily clinicals, a weekly risk meeting to address trends for falls, weights, wounds and incidents/accidents and weekly Medicare Utilization Review. New admission chart	

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F 867	Continued From page 41 This tag was cross referenced to: F584 Based on observation and staff interviews the facility failed to provide a clean and sanitary environment by failing to clean a tube feeding pump and pole for 1 of 1 resident observed with a tube feeding pump and pole. (Resident #34) The facility also failed to provide a safe and sanitary environment when food and other debris was found lodged in 1 of 1 resident ' s HVAC (system used to heal and cool an area) unit. (Resident #15) During the recertification and complaint survey dated 3/30/22 the facility was cited at F584 for failing to clean a feeding pump and feeding pump pole. F641 Based on observation and staff interviews the facility failed to provide a clean and sanitary environment by failing to clean a tube feeding pump and pole for 1 of 1 resident observed with a tube feeding pump and pole. (Resident #34) The facility also failed to provide a safe and sanitary environment when food and other debris was found lodged in 1 of 1 resident's HVAC (system used to heal and cool an area) unit. (Resident #15) During the recertification and complaint survey dated 3/30/22 the facility was cited at F641 for failing to accurately code the Minimum Data Set (MDS) assessment for a resident. During the complaint investigation survey dated 5/10/21 the facility was cited at F641 when the facility failed to accurately code a minimum data set assessment for a resident.	F 867	reviews will be conducted by administrative nursing and MDS no later than the next business day after admission. 3. The administrator, or in his absence his designee, will review all audits conducted weekly for this Plan of Correction to provide needed or required guidance in the QAPI process. 4. F584 The Maintenance Director, or designee will inspect 5 resident rooms weekly for the next 12 weeks. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for review and, if warranted, further action. F641 The Director of Nursing (DON), or designee, will audit 5 MDS's and care plans weekly for 12 weeks to ensure that they accurately reflect the residents wound and diet status. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action. F656 The DON, or designee will audit 5 residents per week for the next 12 weeks of residents who have orders for pain medication/ pain management care, the residents who have orders for oxygen/ respiratory care and residents who have orders for Antipsychotic medications to ensure that the residents care plans	

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F 867	Continued From page 42 During the complaint investigation survey dated 9/20/20 the facility was cited at F641 for failing to accurately code the MDS in the areas of skin conditions and pain. F656 Based on observation, record review, resident and staff interview the facility failed to develop an individualized person-centered care plan for 3 of 32 residents whose care plans were reviewed. (Resident #48, Resident #36, Resident #14) During the recertification and complaint survey dated 3/30/22 the facility was cited at F656 when the facility failed to implement a communication deficit care plan and failed to care plan a resident ' s urinary catheter. During the complaint investigation survey dated 5/10/21 the facility was cited at F656 failed to implement care plan interventions for resident at risk for potential accidents/falls. F690 Based on observations, record review, staff interviews, and physician interviews, the facility failed to maintain an indwelling urinary catheter drainage bag below the bladder to allow for proper drainage and reduce risk for urinary tract infection (Resident #42) and failed to obtain a physician order for indwelling urinary catheter for 2 of 2 residents (Resident #42 and Resident #170) reviewed for urinary catheter. During the complaint investigation survey dated 7/14/20 the facility was cited at F690 for failing to keep a urinary catheter drainage bag from coming in contact with the floor.	F 867	accurately reflects the orders. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action. F690 The DON, or designee, will complete a weekly audit for the next 12 weeks of the residents with an indwelling urinary catheter to ensure that they have a physician order and that the placement of the urinary bag is appropriate. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee for review and, if warranted, further action F883 The DON, or designee, will complete a weekly audit for the next 12 weeks of the new admissions to validate that the new residents have been offered the appropriate vaccinations. Annually, during the period 1-15 October, the DON or designee will ensure that annual vaccines are offered to all residents, with documentation of consent or refusal. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action Audits in these areas will provide the QAPI Committee a focused look at the organization’s delivery of care, it’s assessment capabilities, care planning capabilities and capabilities in the delivery	

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F 867	Continued From page 43 F883 Based on record reviews and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the pneumococcal vaccinations upon admittance into the facility (Resident #47) and offer annual influenza vaccine (Resident #40) for 2 of 5 residents reviewed for immunizations. During the complaint investigation survey dated 5/10/21 the facility was cited at F883 for failing to offer a resident the influenza vaccine, administer the influenza vaccine to a resident after informed consent was signed, and offer a resident the 23 Valent Pneumococcal Polysaccharide vaccine. An interview was conducted with the Administrator on 3/2/23 at 5:51 PM. The Administrator stated that the Quality Assurance Performance Improvement meeting was held monthly to discuss various concerns in the facility. She stated that performance improvement plans were based on concerns the facility received in self-audits, daily rounds and observations, and pharmacy reports. The Administrator stated the staff were constantly being educated through in-services and all staff meetings about the performance improvement plans and the facility ' s progress. The Administrator stated that the facility had faced a lot of staff turnover and she felt this change had directly affected the facility ' s ongoing performance improvement plan..	F 867	of an individualized plan of care. The QAPI Committee will make adjustments as necessary, such as further training or more specific audits, as required.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		3/30/23

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F 883	Continued From page 44 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 45 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the pneumococcal vaccinations upon admittance into the facility (Resident #47) and offer annual influenza vaccine (Resident #40) for 2 of 5 residents reviewed for immunizations. The Findings included: The facility policy for Pneumococcal Vaccine with the revised date October 28,2020 read in part "Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. The resident's medical record shall include documentation that indicates at a minimum the resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal." The facility policy for Influenza Vaccine with the revised date October 27, 2020, read in part "Influenza vaccinations will be routinely offered	F 883	1. Resident #47 was offered the pneumococcal vaccine on 3/22/2023. He did consent to the vaccine. Resident #40 was offered the annual influenza vaccine on 3/21/2023. He did not consent to the vaccine. 2. All residents' immunization records were audited by administrative nursing staff during the period 3/23/2023 – 3/28/2023 to determine vaccine status/consent at admission and annually thereafter. Adjustments were made as necessary. 3. The DON in-serviced the IDCPT and administrative nurses during the period 3/23/2023 – 3/28/2023 on immunization requirements and the timeframes in which vaccinations are to be offered. 4. The DON, or designee, will complete a weekly audit for the next 12 weeks of the new admissions to validate that the new residents have been offered the appropriate vaccinations. Annually, during the period 1-15 October, the DON	

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F 883	Continued From page 46 annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during the time period, or refuses to receive the vaccine." It further read, "the resident's medical record will include documentation that the resident received or did not receive the immunization due to medical contraindication or refusal." 1. Resident #47 was admitted to the facility on 2/16/22 with diagnoses that included a history of a stroke and hypertension. The quarterly MDS assessment dated 12/16/22 revealed Resident #47 had severe cognitive impairment and was coded as not receiving his pneumococcal vaccine. Review of Resident #47's immunization record revealed no documentation that he or his responsible party had been offered, given, or refused the pneumococcal vaccine. An interview was completed with the Infection Control Nurse on 3/2/23 at 3:04pm. The Nurse indicated she was new to the position and facility and had no information regarding the pneumococcal or influenza vaccinations. An interview was completed with Administrator #2 on 3/2/23 at 4:54pm. She revealed there had been a change in leadership at the facility which led to a miscommunication to nursing staff, that resulted in residents not receiving vaccinations. 2. Resident #40 was admitted to the facility on 3/18/20 with diagnoses that included history of a stroke and high blood pressure.	F 883	or designee will ensure that annual vaccines are offered to all residents, with documentation of consent or refusal. Results of these audits will be presented to the facility monthly Quality Assurance and Performance Improvement (QAPI) Committee monthly for review and, if warranted, further action.	

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F 883	Continued From page 47 The quarterly Minimum Data Set (MDS) assessment dated 12/29/22 revealed Resident #40 had severe cognitive impairment and was coded as receiving his last influenza vaccine on 10/21/21. Review of Resident #40's immunization record revealed no documentation that he or his responsible party had been offered, given, or refused the influenza vaccine. An interview was completed with the Infection Control Nurse on 3/2/23 at 3:04pm. The Nurse indicated she was new to the position and facility and had no information regarding the pneumococcal or influenza vaccinations. An interview was completed with Administrator #2 on 3/2/23 at 4:54pm. She revealed there had been a change in leadership at the facility that led to a miscommunication to nursing staff, which resulted in residents not receiving vaccinations.	F 883		