STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 1/23/23 through 1/26/23. The facility was found out of compliance with the requirement CFR 483.73, Emergency Preparedness and a federal deficiency was cited. See #KJ6011	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2	E 039		3/17/23

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

Electronically Signed | 02/27/2023

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years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional

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exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario,

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and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem

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statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements,

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directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to

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and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]

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(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

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E 039	Continued From page 8 (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide documented evidence of	E 039	The statements made on this plan of correction are not an admission to and do	

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E 039	Continued From page 9 any emergency preparedness (EP) testing or drills. The findings included: Review of the EP plan was reviewed on 1/25/23. The last documented evidence of any testing or drills was on 9/8/21 when an active shooter drill was conducted. An interview was completed on 1/25/23 at 11:20 AM with the Maintenance Director. He stated he had only been employed at the facility for 3 months and that he had not conducted any drills or attempted to coordinate an tabletop or actual EP testing. He stated he was not able to locate any other documented drill or testing since the active shooter drill done on 9/8/21. A telephone interview was attempted on 1/25/23 and 1/26/23 with messages left for the previous facility Maintenance Director with no return calls as of exit on 1/26/23. An interview was completed on 1/26/23 at 12:16 PM with Administrator #1. He stated he did not expect the previous Maintenance Director to return surveyor calls and suspected he removed documented evidence of testing and drills conducted after 9/8/21. He stated he was not aware that the EP was not up to date and that he recently started as the interim Administrator on 1/3/23. Administrator #1 stated it was his expectation that the facility conduct monthly drills and complete an actual live EP test or at minimum a tabletop test annually.	E 039	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. E0039 1. Corrective action for resident(s) affected by the alleged deficient practice: Review of the EP plan was completed on 1/25/23. The last documented evidence of any testing or drills was on 9/8/21 when an active shooter drill was conducted. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents are affected by the facility not completing any Emergency Preparedness drills. There was an actual emergency that happened in the facility on 02/07/2023 at approximately 3:00 pm. This event qualified as an annual community based full-scale exercise. Another exercise or drill will be scheduled within the next 6 months. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The facility will conduct an emergency	

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E 039	Continued From page 10	E 039	preparedness drill twice during a rolling calendar year. The drills will consist of: a. an annual community based full-scale exercise (facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event), and (one of the following) b. a second full-scale exercise that is community-based or an individual, facility based functional exercise; or c. mock disaster drill; or d. a tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan e. At the end of exercise/drill, analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the facility's emergency plan, as needed. f. Education will be provided to the administrator and leadership team by the Regional Director of Operations to ensure compliance with emergency preparedness corporate policies.	

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E 039	Continued From page 11	E 039	Administrator was educated on the company policy and procedures for Emergency Operations Plan and on the CMS guidelines on having two exercises per year on 02/23/23. Audits will be conducted by the Administrator and/or designee one week prior to the monthly QAPI meeting to ensure that the facility is in compliance. The Regional Director of Operations will complete biannual check to ensure that compliance is being upheld by the facility and Administrator. 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. Administrator and/or designee are responsible for implementing the acceptable plan of correction. Starting on 2/24/23, the Administrator or designee will monitor utilizing E039 Emergency Preparedness monitoring QA tool. Monthly audits will be completed for 12 months of consecutive audits or until 100% compliance has been achieved. Administrator will bring this to QAPI on a monthly basis for twelve months. Date of Compliance: 03/17/2023	
F 000	INITIAL COMMENTS The survey team entered the facility on 1/23/23 to conduct a recertification and complaint investigation survey and exited on 1/26/223. The	F 000		

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F 000	Continued From page 12 survey team returned to the facility on 2/7/23 to obtain additional information and exited on 2/9/23. Therefore, the exit date was changed to 2/9/23. Event ID # KJ6011. The following intakes were investigated: NC 197977, NC194892, NC196912, NC189490, NC195047, NC195255, NC192347, NC193823, & NC193714 13 of the 27 complaint allegations resulted in deficiencies. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F686 at a scope and severity (K) CFR 483.70 at tag F835 at a scope and severity (K). The tag F686 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/6/22 and was removed on 2/8/23. An extended survey was conducted.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		3/17/23

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F 561	Continued From page 13 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to honor a resident's choice related to showers (Resident #10) for 1 of 1 resident reviewed for choices. The findings included: Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included a stroke, muscle weakness, congestive heart failure (CHF) and diabetes type 2. A quarterly Minimum Data Set (MDS) assessment dated 1/7/23 indicated Resident #10 had moderately impaired cognition, required limited assistance with transfers and extensive	F 561	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. F561 1. Corrective action for resident(s) affected by the alleged deficient practice:	

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assistance with bathing. She displayed no behaviors or refusal of care.

A review of Resident #10's active care plan, last reviewed 1/12/23, included a focus area for Activities of Daily Living (ADL) self-care performance deficit.

A review of Resident #10's nursing progress notes from 12/1/22 to 1/24/23 revealed no refusals of showers documented.

Review of the Nurse Aide (NA) Care Guide indicated Resident #10 was scheduled to receive a shower on Wednesday and Saturday day shift (7:00 AM to 3:00 PM).

Resident #10's Nurse Aide Flow Records for December 2022 and January 2023 were reviewed and revealed they were not initialed as a shower received nor refused on 12/17/22, 12/24/22, 12/28/22, 12/31/22, 1/4/23, 1/7/23, and 1/11/23.

On 1/23/23 at 9:31 AM, an interview occurred with Resident #10 who stated she couldn't remember when she received a shower last but would like to have one. She stated she got a "wash up" in the mornings. Resident #10 was clean and free from odors, but her skin was dry in appearance, at the time of the interview.

An interview occurred with Nurse Aide (NA) #1 on 1/25/23 at 3:28 PM. She was familiar with Resident #10 and was often assigned to care for her on Wednesdays. NA #1 reviewed Resident #10's Nurse Aide Flow Records for showers, which indicated she had marked NA (not applicable) on 1/11/23. NA #1 stated this was marked because B bed residents received

Resident #10 discharged from the facility on 1/29/2023.

2. 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 02/21/2023, the Nurse Manager/Minimum Data Set nurse interviewed all current alert and oriented residents for their preference regarding shower days. The Director of Nursing / Minimum Data Set nurse will then task the requested shower schedule to Point Click Care task to fire to the Certified Nursing Aides for documentation. This will be completed by 03/06/2023. For current non-alert and oriented residents, the Certified Nursing Aides were educated by the nurse manager on the new facility shower schedule and that it should be followed as posted. Showers will be documented in the personal care task of Point Click Care. This will be completed by 03/17/2023.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 2/23/2023, Director of Nursing, Nurse Consultant and the Nurse Manager began education to all full time, part time, PRN and agency Nurses and Certified Nursing Aides on the following: new revised shower schedule, refusal documentation,

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F 561	Continued From page 15 showers on the evening shift (3:00 PM to 11:00 PM). NA #1 reviewed Resident #10's Nurse Aide Care Guide and Nurse Aide Flow Record and verified they stated she was to receive a shower on Wednesday and Saturday day shift. NA #3 was assigned to Resident #10 on 12/31/22 (Saturday) and 1/4/23 (Wednesday) and had marked shower provided as not applicable. NA #3 was unable to be interviewed. Multiple phone call attempts were made for NA #4 but were unsuccessful. NA #4 was assigned to Resident #10 on 12/24/22 (Saturday) and 1/7/23 (Wednesday) and had left the entry for showers blank. NA #5 was assigned to Resident #10 on 12/17/22 (Saturday) and had left the entry blank. NA #5 was unable to be interviewed. The Director of Nursing (DON) #1 was interviewed on 1/26/23 at 10:00 AM. She reviewed Resident #10's Nurse Aide Flow Record for showers and confirmed there were some missing showers and showers marked as not applicable. The acting DON explained Resident #10 had moved from the A bed to the B bed at the end of December 2022, changing her showers from the day shift to the evening shift. She further stated the NA Care Guide and NA Flow Records were not changed to reflect a shower was required on the evening shift of Wednesdays and Saturdays, thus causing Resident #10 to miss receiving a shower. The acting DON stated she should have updated these records.	F 561	and documentation of completion in Point Click Care tasks. 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 Aides who give residents care in the facility. As of 3/17/2023, any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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 Nursing and/or designee will monitor compliance utilizing the F561 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor resident□s preference of shower□s and shower compliance. The Social Worker or designee will monitor satisfaction with showers weekly x 2 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing 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	

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F 561	Continued From page 16	F 561	necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set nurse, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/17/2023	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		3/17/23

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F 580	Continued From page 17 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Wound Nurse, Director of Nursing (DON) #2, Medical Director (MD) #2, and Nurse Practitioner (NP) #2 interviews, the facility failed to notify the MD #2 or NP #2 that Resident #16's developed an abrasion to her left lateral calf under her immobilizer on 9/6/22 resulting in no assessment or treatment until 9/13/22 when the area was discovered as an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar). The Wound Physician noted on 9/13/22 the pressure ulcer as measuring 10 centimeters (cm) by 5 cm with 5% of thick adherent black necrotic tissue (eschar) 80% thick adherent devitalized necrotic tissue (slough) and 15%	F 580	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. F580 1. Corrective action for resident(s) affected by the alleged deficient practice:	

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F 580	Continued From page 18 granulation tissue. This was for 1 of 4 residents reviewed for pressure ulcers (Resident #16). Immediate jeopardy began on 09/06/22 when an abrasion to Resident #16's left lateral calf was identified underneath the leg immobilizer and did not notify or consult MD #2 for wound treatment orders. Immediate jeopardy was removed on 2/8/23 when the facility provided and implemented an acceptable credible table allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the facility completes all staff training and ensure monitoring systems put into place are effective. The findings included: Resident #16 was admitted on 7/24/19 with cumulative diagnoses of Dementia, Congestive Heart failure, Chronic Kidney Disease, Coronary Artery Disease and osteoporosis. Review of a nursing note dated 8/17/22 at 5:20 PM read she returned from the emergency room on 8/17/22 wearing a left leg immobilizer due to a left distal femur fracture with orders to wear the mobilizer until she was evaluated on 9/6/22 by the orthopedic physician and to check her skin daily to her left lower extremity due to the presence of the leg immobilizer. Review of an orthopedic Physician Assistant (PA) note dated 9/6/22 read there was an observed abrasion to her left lower lateral leg. The note included orders to pad the area under her	F 580	For resident #16, a corrective action was obtained on 9/16/2022. The Medical Director and Responsible Party were notified on 9/16/2022 by the Director of Nurses that resident #16 had developed an abrasion to the left lateral calf that resulted in the development of an unstageable pressure ulcer to the area under her immobilizer and that an error in timely assessment and initiating ordered treatment had occurred. 2. 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 2/7/2023, the Interim Director of Nurses audited notification for residents that were potentially impacted by this practice by reviewing 100% of post appointment documents and any resulting orders received from the appointment, for the last 30 days. The audit was done for completion of notification of the attending physician and the responsible party. The results included: No other concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Root Cause Analysis was completed on 2/07/2023 with the following staff in attendance: Administrator, Interim Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse	

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immobilizer and consult wound management for wound care orders.

A telephone interview was completed on 2/6/23 at 9:00 AM with the Orthopedic Physician Assistant (PA). He stated on 9/6/22, he observed an abrasion to Resident #16's left lower leg and wrote on his consult note orders to pad the area for protection and to consult the wound provider for wound care orders.
Review of the electronic medical record (EMR) did not include any documented evidence that MD #2 was notified of the abrasion discovered at the orthopedic visit on 9/6/22.
A telephone interview was completed on 2/2/23 at 2:50 PM with the Wound Nurse. She stated she thought she recalled a blister on Resident #16's left lower leg under her immobilizer that popped on 9/6/22 and she just covered it with a dry dressing and assumed the orthopedic PA would write wound care orders. She stated she did not notify MD #2 on 9/6/22 when the abrasion was first identified by the orthopedic PA. The Wound Nurse stated she did not read the orthopedic consult note on 9/6/22 because the receiving nurse (Nurse #14) should have reviewed it and implemented any new orders.

Review of a Wound Physician note dated indicated she was asked to assess Resident #16 for an unstageable pressure to her left lateral calf on 9/13/22.

A telephone interview was completed on 2/2/23 at 4:41 PM with MD #2. He stated he was not notified about Resident #16's pressure ulcer to her left lateral calf until 9/13/22 when the Wound Physician called him because she was concerned about the appearance of the wound and

Consultant and the Medical Director. Root cause analysis was conducted related to staff failure to notify the attending physician, upon return from an appointment, of newly received orders. Upon interview of the nursing staff/agency it was determined that the root cause was that the nurse failed to put the order in the electronic health record so that the treatment was initiated and the referral could have been followed up on in the daily clinical meeting. This resulted in the physician not being notified of the new abrasion and ordered treatment. The facility administration□s failed to provide effective oversight and leadership to ensure effective systems were in place related to follow up of orders and notification to the physician of new orders or recommendations received from an appointment.

On 02/7/2023, the Interim Director of Nurses/Quality Assurance Nurse Consultants began in-service of 100% of all licensed nurses, full time, part-time and as needed nurses, including agency. The education included: The Change in Condition/Notification/Documentation Process of the attending physician/responsible party/resident, to include notification of changes in skin/wounds, newly received orders, following return from an appointment and the importance of following the post appointment process. When a resident returns from an appointment, the nurse is to obtain the post visit note and review it for new orders or recommendations. The

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F 580	Continued From page 20 suspected an infection. He stated nobody from the facility notified him of a pressure ulcer until then. He stated he would have expected to be notified due to the risk associated with a pressure ulcer getting infected and he would have given wound care orders on 9/6/22 if the orthopedic PA had not. He stated Resident #16's pressure ulcer that developed underneath an immobilizer was avoidable and any pressure ulcer that was not treated would deteriorate and could lead to infection, sepsis (blood infection) and possible osteomyelitis. A telephone interview was completed on 2/1/23 at 4:28 PM with DON #2. She stated apparently nobody knew about the area identified by the orthopedic office on 9/6/22 until a staff member told the Wound Nurse that there was drainage coming from Resident #16's immobilizer on 9/13/22. She stated she did not read the orthopedic consult note until 9/13/22 when it was discovered Resident #16 had an unstageable pressure ulcer. DON #2 stated after her investigation it was determined that Nurse #14 did not implement the wound care orders from the 9/6/22 orthopedic consult. She stated an untreated open area underneath an immobilizer was avoidable and could lead to complications such as a wound infection sepsis (blood infection) and possible osteomyelitis. Administrator #1 was notified of the immediate jeopardy on 2/6/23 at 5:33 PM. Administrator #1 provided the following credible allegation for the immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as	F 580	nurse is to notify the physician and responsible party/resident. The nurse is to transcribe any new orders. The post visit note is sent to medical records and will be uploaded into the electronic health record within 72 hours post visit. The interdisciplinary team will review the post visit note and any applicable orders as part of the Daily Clinical Process. The interdisciplinary team will review the hard copy information from the post visit note to confirm that needed orders are contained in the electronic medical record. If the resident returns without a post visit note or orders, it is the responsibility of the nurse to follow up and call the physician□s office to obtain any new orders and then transcribe those orders. The nurse will as well notify the responsible party/resident and document the notification. On 2/7/2023, the Interim Director of Nurses/Administrator and interdisciplinary team were educated on the expectation that the post appointment process, to include newly received orders/progress notes or other physician/NP/PA information received from an appointment involving a change in condition such as a wound, will be followed as part of the Daily Clinical Review Process. The process is to include review of notification of the attending physician and responsible party and that the notification is documented in the electronic health record. This education was completed by the Quality Assurance Nurse Consultant. As of 2/8/2023, no Licensed Nurses will work	

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a result of the noncompliance.
On 09/06/22 Resident #16 returned from an orthopedic appointment and the transporter gave the nurse the post visit order sheet. The orthopedic MD noted: that a new abrasion was noted to the left lateral aspect of the left lower leg. New orders were received for treatment to the area underneath the immobilizer. The orders included that the dressing and padding must be changed daily, and a wound management consult was advised. The nurse placed the after-visit note/order sheet in the medical records box as she had been instructed to do in the past. It was scanned into PCC on 09/12/22, but no orders were noted or transcribed from that post visit note as no one was aware that there were new orders. On 09/13/22 the Certified Nurse Aide was lifting the resident's immobilized leg and felt a wet area on the immobilizer. On 9/13/22 the resident went to an orthopedic appointment and new orders were received. On 9/13/2022 the wound nurse reviewed the orders and upon assessment of resident #16, noted a dressing placed by the orthopedic doctor to the left lateral calf. On 09/13/22 the wound doctor was notified and evaluated the left lower leg and noted areas to the left lateral calf and left anterior knee. Treatments were initiated to the left lateral unstageable calf wound to cleanse the wound, apply Santyl for 30 days and Gentamycin for 14 days with calcium alginate once daily for 30 days. Per physician's post visit note the treatment to the deep tissue injury to the left anterior knee was to cleanse the wound, apply skin prep to area and cover with protective dressing once daily for 30 days.
On 2/7/2023 the Interim Director of Nurses audited notification for residents that were potentially impacted by this practice by reviewing

without the education completed. This is to include agency and licensed nurse staff. The Interim Director of Nurses and Administrator are responsible to ensure all applicable 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 and agency nurses as well as any newly hired interdisciplinary team members.

After 2/08/23, the Interim Director of Nursing will continue to be responsible to ensure new Licensed Nurses/agency are educated on the applicable policies and procedures related to nursing follow up post appointment to assure the notification process is completed and that new orders are initiated to prevent serious complications that might occur for failing to follow these processes. Education will be completed by the Interim Director of Nurses/RN Unit Manager prior to working their first shift. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

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.

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F 580	Continued From page 22 100% of post appointment documents and any resulting orders received from the appointment, for the last 30 days. The audit was done for completion of notification of the attending physician and the responsible party. Root Cause Analysis was completed on 2/07/2023 with the following staff in attendance: Administrator, Interim Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was conducted related to staff failure to notify the attending physician, upon return from an appointment, of newly received orders. Upon interview of the nursing staff/agency it was determined that the root cause was that the nurse failed to put the order in the electronic health record so that the treatment was initiated, and the referral could have been followed up on in the daily clinical meeting. This resulted in the physician not being notified of the new abrasion and ordered treatment. The facility administration's failed to provide effective oversight and leadership to ensure effective systems were in place related to follow up of orders and notification to the physician of new orders or recommendations received from an appointment. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. On 02/7/2023, the Interim Director of Nurses/Quality Assurance Nurse Consultants began in-service of 100% of all licensed nurses, full time, part time and as needed nurses, including agency. The education included: The Change in Condition/Notification/Documentation Process of the attending physician/responsible	F 580	Utilizing the F580 Quality Assurance Audit Tool, the Director of Nurses or designee will monitor the post appointment process for compliance with notification of the Medical Director/Responsible Party for changes in condition/new orders and the implementation of new orders/needed assessments 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 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 Date of Compliance: 03/17/2023	

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F 580	Continued From page 23	F 580		

party/resident, to include notification of changes in skin/wounds, newly received orders, following return from an appointment and the importance of following the post appointment process. When a resident returns from an appointment, the nurse is to obtain the post visit note and review it for new orders or recommendations. The nurse is to notify the physician and responsible party/resident. The nurse is to transcribe any new orders. The post visit note is sent to medical records and will be uploaded into the electronic health record within 72 hours post visit. The interdisciplinary team will review the post visit note and any applicable orders as part of the Daily Clinical Process. The interdisciplinary team will review the hard copy information from the post visit note to confirm that needed orders are contained in the electronic medical record.
If the resident returns without a post visit note or orders, it is the responsibility of the nurse to follow up and call the physician's office to obtain any new orders and then transcribe those orders. The nurse will as well notify the responsible party/resident and document the notification.
On 2/7/2023 the Interim Director of Nurses/Administrator and interdisciplinary team were educated on the expectation that the post appointment process, to include newly received orders/progress notes or other physician/NP/PA information received from an appointment involving a change in condition such as a wound, will be followed as part of the Daily Clinical Review Process. The process is to include review of notification of the attending physician and responsible party and that the notification is documented in the electronic health record. This education was completed by the Quality Assurance Nurse Consultant.
As of 2/8/2023, no Licensed Nurses will work

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F 580	Continued From page 24 without the education completed. This is to include agency and new staff. The Interim 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 and agency nurses as well as any newly hired interdisciplinary team members. After 2/08/23 the Interim Director of Nursing will be responsible to ensure Licensed Nurses are educated on the applicable policies and procedures related to nursing follow up post appointment to assure the notification process is completed and that new orders are initiated to prevent serious complications that might occur for failing to follow these processes Alleged date of immediate jeopardy removal 02/08/23. On 02/09/23, the facility's credible allegation for Immediate Jeopardy removal effective 02/08/23 was validated by staff interviews and record review. Staff were interviewed to validate in-service completion. Review of the appointment and order follow up process education was completed. Review of the appointment/order follow up sheet was completed, and the Quality Assurance (QA) Committee met to discuss the appointment/order follow up findings. Immediate jeopardy was removed on 2/8/23.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		3/17/23

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F 600	Continued From page 25 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff family, Emergency Room (ER) Physician, Medical Director #2, Nurse Practitioner (NP) #1 interviews and record review, the facility failed to protect the resident from injury of unknown origin (right proximal tibia/fibula fracture) resulting in physical harm. This was for 1 (Resident #16) of 8 residents reviewed for accidents. The findings included: Resident #16 was admitted on 7/24/19 with cumulative diagnoses of Dementia, Congestive Heart failure, Chronic Kidney Disease, Coronary Artery Disease, and osteoporosis. Review of Resident #16's care plan included a care plan for osteoporosis with a risk for fractures dated last revised on 7/9/21. Interventions included observation, document and report any signs or symptoms of an acute fracture, compression fractures, loss of height and complaints of back pain. Resident #16 was also care planned on 9/11/19 for an actual fall and the interventions included two staff assist with	F 600	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. F600 1. Corrective action for resident(s) affected by the alleged deficient practice: On 01/18/2023, Resident#16 had a head to toe assessment was completed by the assigned nurse with the following results no other areas of concern from the attending nurse or the resident. Telephone order obtained for RLE Doppler to rule out Deep Vein Thrombosis since resident has a history of Deep Vein Thrombosis. Attending nurse practitioner	

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F 600	Continued From page 26 transfers dated 10/23/19. The quarterly Minimum Data Set (MDS) dated 11/23/22 indicated she had moderate cognitive impairment, exhibited no behaviors, required extensive to total assist with her activities of daily living. Review of a nursing note dated 1/18/23 at 10:50 AM read Resident #16 was transferred to the hospital due to right lower extremity (RLE) pain. Review of a nursing note dated 1/18/23 at 10:50 AM read Resident #16 was transferred to the hospital due to right lower extremity (RLE) pain. Review of the emergency room (ER) Physician's report dated 1/18/23 read as follows: Resident #16 complained of leg pain for several days and today the facility noted some swelling and discoloration of her RLE. The report read the facility was concerned about a deep vein thrombosis (DVT) and transferred her to the ER for an evaluation. Resident #16 has dementia and bed bound. Resident #16 stated her RLE had been hurting for several day after she fell. She stated she did not remember exactly how or when she fell and denied that anyone hurt her. The report read despite the facility's concern for a DVT, her RLE appearance was concerning for a traumatic injury with bruising and swelling. X-rays revealed a proximal tibia fracture and osteopenia noted. The report read with osteopenia, Resident #16's bed bound status, it was suspected the fracture may have occurred during a position change or during a transfer and doubtful it occurred from a fall. The report read she contacted NP #1 at the facility and NP #1 reported Resident #16 had complained of leg	F 600	also directed staff to assess pedal and popliteal pulses and perform test for Homan's Sign on RLE. Follow-up appointment with orthopedics obtained for 01/23/2023 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 1/ 25/2023 the DON/assigned nurses identified residents that were potentially impacted by this practice by completing head to toe audits on all resident on the CNA s assignment with a BIMS less than 13. The results included: No concerns identified. On 2/01/2023, residents with BIMS of 13 or above were interviewed by SW for any concerns related to care or any unidentified falls within the last 14 days. Results included: No concerns identified. On 2/1/2023 the Nurse Consultant audited all resident care plans for compliance with an identified transfer status. The results included: 43 of 53 were in compliance. On 2/1/2023 the nurse consultant updated the care plans to reflected the current resident transfer status. On 2/01/2023 the DON began observation of Nurses/CNA s/Med Aide s/Agency s scheduled to work day and evening shift s ability to access the Kardex via demonstration. The results included: 8 of 9 nursing staff were able to access the Kardex and identify how to locate the transfer status. On 2/01/2023 the DON educated the one nursing staff and they were able to demonstrate understanding via return demonstration.	

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F 600	Continued From page 27 pain for several days but denied any known falls or injuries. NP #1 as advised for the need for orthopedic follow up and she was placed in an immobilizer then discharged back to the facility with orders for Tylenol or Motrin for pain. A telephone interview was completed on 1/25/23 at 11:20 AM with ER Physician. She stated she treated Resident #16 on 1/18/23 and noted her fracture to her right tibia/fibula fracture was acute with noted swelling, pain and bruising. She recalled calling NP #1 and informed her of her findings with the need for Resident #16 to see an orthopedic Physician as soon as possible and she recommended Tylenol as needed for pain. Review of a nursing note dated 1/18/23 at 3:30 PM read the emergency room (ER) was contacted for report on Resident #16. The note read the ER nurse reported the following: "The good thing is that it looks to be an old fracture based on calcification and callus formation and the ER Physician stated it was indicative of an old fracture. NP #1 was notified, and she stated she would contact the ER Physician and let the facility know what orders or next step were needed. NP #1 called back and informed the writer that she spoke with the ER Physician and confirmed the ER findings suggested an old RLE fracture. This note was written by Director of Nursing (DON) #1. An interview was completed on 2/7/23 at 11:30 AM with DON #1. She stated she assessed Resident #16's right leg on 1/18/23 due to Nursing Assistant (NA) #8 reporting her right knee appeared bruised and swollen but she did not complain of any pain, and nobody had reported acute pain to her in the days prior. She stated Resident #16 did often complain of pain all over	F 600	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/23/2023, the Director of Nurses/RN Manager began in-service of all nursing staff (including agency) on accessing the Kardex prior to care, how to access the Kardex, using the correct transfer technique and reporting any incidents that occur while caring or transferring a resident to the assigned nurse as well as the definition of injuries of unknown origin and what relates to abuse/neglect. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 3/17/2023 will not be allowed to work until the training is completed. 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 DON/RN Unit Manager will monitor Transfer Safety and Kardex Access weekly for 4 weeks and monthly for 3 months or until resolved for compliance with safe and appropriate resident transfers. Staff will be observed on various shifts and days of the week to include weekends for compliance with accessing the Kardex and performing the appropriate transfer. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nurses to ensure corrective action is initiated as appropriate.	

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F 600	Continued From page 28 due to her osteoporosis. She notified MD #2 and he ordered to be sent to the ER for an evaluation. She stated she called the hospital on 1/18/23 to get an update of Resident #16's condition and spoke to an ER Nurse but did not recall her name. She stated informed Administrator #1 on 1/18/23 what was reported to her by the ER Nurse. DON #1 stated at no time did the facility suspect staff error there did not perceive it as neglectful. An interview was completed on 1/25/23 at 2:53 PM with NA #8. She recalled seeing Resident #16's right leg the morning of 1/18/23 and noted bruising and swelling. She stated Resident #16 did not complain of pain to her right leg, but she got DON #1 to assess it. She stated she was assigned Resident 16 on first shift on 1/17/23 and there was no evidence of injury or any voiced pain. An interview was completed on 1/25/23 at 3:00 PM with NA #10. She confirmed working with Resident #16 on night shift on 1/17/23 and she did not observe any evidence of an injury to Resident #16's right leg and she did not complain of pain. An interview was completed on 2/3/23 at 3:40 PM with NA #9. She confirmed working with Resident #16 on second shift on 1/17/23 and she did not observe any evidence of an injury to Resident #16's right leg and she did not complain of pain. Review of a NP #1 note untimed dated 1/20/23 read Resident #16 reported RLE pain on 1/18/23 and staff noted her RLE was significantly more swollen. She was sent to the ER and NP #1 spoke with the ER Physician who stated she was	F 600	Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with splint application. The weekly 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: March, 17, 2023	

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F 600	Continued From page 29	F 600		

diagnosed with a proximal right tibia/fibula fracture that was not likely an acute finding due to severe osteopenia, non-ambulatory and no reports of a fall or injury according to the documentation and staff.

A telephone interview was completed on 1/25/23 at 1:43 PM with NP #1. She recalled speaking with the ER Physician on 1/18/23 but interpreted their conversation indicated Resident #16's fracture was old, calcified and osteopenia. She stated documented Resident #16's complaints of pain for several days because that was what DON #1 and facility staff reported to her. She stated DON #1 and Administrator #1 were notified around the same time when DON #1 called the ER and spoke with an ER Nurse who reported the same interpreted information as she did. NP #1 stated she did not read the ER documentation and was not aware Resident #16 had an acute fracture until she returned from her orthopedic appointment on 1/23/23. NP #1 stated she did not think there was any evidence of staff neglecting to provide all safety precautions related to Resident #16.

An observation and family interview were conducted on 1/23/23 at 11:18 AM. Resident #16 was sitting up in her wheelchair with a right lower leg immobilizer to her leg. Resident #16 denied pain at this time. The family member stated last week she was notified on 1/18/23 of a possible fracture to Resident #16's right lower leg. She stated Administrator #1 spoke to her and said the fracture diagnosed in the ER on 1/18/23 was an old fracture and that she had not experienced any falls, staff had not reported any injury until 1/18/23 and it was suspected the injury could have happened during routine care from rolling her or

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F 600	Continued From page 30 transferring her using the mechanical lift. She stated the orthopedic Physician she saw today told her it was not an old fracture but new. An interview was completed on 1/23/23 at 1:57 PM with Administrator #1 who stated he was informed by NP #1 or DON #1 that Resident #16's injury was not an acute injury and was due to osteopenia. An interview was completed on 1/26/23 at 12:16 PM with Administrator #1. He stated the facility should considered the injury to Resident #16's right leg suspicious but at the time it was identified on 1/18/23 and due to inconsistencies in what the facility understood and what was documented in the ER report, he did not. A telephone interview was completed on 2/8/23 at 1:30 PM with MD #2. He stated although he could not say for sure, but he felt that the transfer the shower was the "anticipated etiology" for the fracture. He further stated that it is possible that Resident #16 may not have required pain medication immediately and that the leg may have swollen days after the break.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		3/17/23

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F 610	Continued From page 31 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff family, Emergency Room (ER) Physician, Medical Director #2, Nurse Practitioner (NP) #1 interviews and record review, the facility failed to provide evidence of an investigation for an injury of unknown origin (right proximal tibia/fibula fracture) that occurred on 1/18/23. The facility failed to investigate the injury until the surveyor began intervention and investigation on 1/24/23. The facility failed to provide evidence other officials in accordance with State law to include to the State Survey Agency were notified within 2 hours of being made aware of the injury that occurred on 1/18/23 and evidence that an investigation report was submitted within the required 5 working days of the incident. This was for 1 (Resident #16) of 8 residents reviewed for accidents. The findings included: Resident #16 was admitted on 7/24/19 with cumulative diagnoses of Dementia, Congestive Heart failure, Chronic Kidney Disease, Coronary Artery Disease, and osteoporosis. The quarterly Minimum Data Set (MDS) dated 11/23/22 indicated she had moderate cognitive impairment, exhibited no behaviors, required	F 610	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. F610 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility failed to provide evidence of an investigation for an injury of unknown origin (right proximal tibia/fibula fracture) that occurred on 1/18/23 for Resident #16. The facility failed to provide evidence other officials in accordance with State law to include to the State Survey Agency were notified within 2 hours of being made aware of the injury that occurred on 1/18/23 and evidence that an investigation	

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F 610	Continued From page 32 extensive to total assist with her activities of daily living. Review of a nursing note dated 1/18/23 at 10:50 AM read Resident #18 was transferred to the hospital due to right lower extremality (RLE) pain. Review of the emergency room (ER) Physician's report dated 1/18/23 read as follows: Resident #16 complained of leg pain for several days and today the facility noted some swelling and discoloration of her RLE. The report read the facility was concerned about a deep vein thrombosis (DVT) and transferred her to the ER for an evaluation. Resident #16 has dementia and bed bound. Resident #16 stated her RLE had been hurting for several day after she fell. She stated she did not remember exactly how or when she fell and denied that anyone hurt her. The report read despite the facility's concern for a DVT, her RLE appearance was concerning for a traumatic injury with bruising and swelling. X-rays revealed a proximal tibia fracture and osteopenia noted. The report read with osteopenia, Resident #16's bed bound status, it was suspected the fracture may have occurred during a position change or during a transfer and doubtful it occurred from a fall. The report read she contacted NP #1 at the facility and NP #1 reported Resident #16 had complained of leg pain for several days but denied any known falls or injuries. NP #1 as advised for the need for orthopedic follow up and she was placed in an immobilizer then discharged back to the facility with orders for Tylenol or Motrin for pain. A telephone interview was completed on 1/25/23 at 11:20 AM with ER Physician. She stated she	F 610	report was submitted within the required 5 working days of the incident. The 24 hour report was submitted to N.C. Department of Health Human Services by the administrator on 01/24/2023 after receiving a conflicting report from the 01/23/2023 orthopedic appointment. The 5 day follow up was submitted to NC DHHS was submitted by the administrator on 01/30/2023 at 5:36 pm. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 2/20/23, the administrator and corporate clinical nurse completed an audit of 100% of all injuries of unknown origin for the past 6 months to include the electronic resident health records and state reportable files. All other injuries of unknown origin were reported to the state within specified time frames set forth by CMS guidelines. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/20/23, the regional clinical nurse began 100% of administrative staff on the Abuse Prohibition Policy. All training is to be completed by 2/24/23. If training is not completed, the employee will not be allowed to work until completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 610	Continued From page 33 treated Resident #16 on 1/18/23 and noted her fracture to her right tibia/fibula fracture was acute with noted swelling, pain and bruising. She recalled calling NP #1 and informed her of her findings with the need for Resident #16 to see an orthopedic Physician as soon as possible and she recommended Tylenol as needed for pain. Review of a nursing note dated 1/18/23 at 3:30 PM read the emergency room (ER) was contacted for report on Resident #16. The note read the ER nurse reported the following: "The good thing is that it looks to be an old fracture based on calcification and callus formation and the ER Physician stated it was indicative of an old fracture. NP #1 was notified, and she stated she would contact the ER Physician and let the facility know what orders or next step were needed. NP #1 called back and informed the writer that she spoke with the ER Physician and confirmed the ER findings suggested an old RLE fracture. This note was written by Director of Nursing (DON) #1. An interview was completed on 2/7/23 at 11:30 AM with DON #1. She stated she assessed Resident #16's right leg on 1/18/23 due Nursing Assistant (NA) #8 reporting her right knee appeared bruised and swollen but she did not complain of any pain, and nobody had reported acute pain to her in the days prior. She stated Resident #16 does often complain of pain all over due to her osteoporosis. She notified MD #2 and he ordered to be sent to the ER for an evaluation. She stated she called the hospital on 1/18/23 to get an update of Resident #16's condition and spoke to an ER Nurse but did not recall her name. She stated informed Administrator #1 on 1/18/23 what was reported to her by the ER Nurse.	F 610	and/or in compliance with regulatory requirements. Administrator and/or designee are responsible for implementing the acceptable plan of correction. On 2/24/23, the Administrator or designee will begin monitoring compliance utilizing F-tag 610 Investigate/Prevent /Correct Alleged Violation monitoring QA tool. Monitoring will include review of resident clinical notes as part of the Daily Clinical Review Process for 5 residents daily x 4 then weekly x 3, and then monthly x 2 or until resolved. The ongoing auditing program will be reviewed at the monthly Quality Assurance Meeting until deemed as no longer necessary for compliance with reporting abuse and neglect. Date of Compliance: 03/17/2023	

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An interview was completed on 1/25/23 at 2:53 PM with NA #8. She recalled seeing Resident #16's right leg the morning of 1/18/23 and noted bruising and swelling. She stated Resident #16 did not complain of pain to her right leg, but she got DON #1 to assess it. She stated she was assigned Resident #16 on first shift on 1/17/23 and there was no evidence of injury or any voiced pain.
An interview was completed on 1/25/23 at 3:00 PM with NA #12. She confirmed working with Resident #16 on night shift on 1/17/23 and she did not observe any evidence of an injury to Resident #16's right leg and she did not complain of pain.
An interview was completed on 2/3/23 at 3:40 PM with NA #9. She confirmed working with Resident #16 on second shift on 1/17/23 and she did not observe any evidence of an injury to Resident #16's right leg and she did not complain of pain.
Review of a NP #1 note untimed dated 1/20/23 read Resident #16 reported RLE pain on 1/18/23 and staff noted her RLE was significantly more swollen. She was sent to the ER and NP #1 spoke with the ER Physician who stated she was diagnosed with a proximal right tibia/fibula fracture that was not likely an acute finding due to severe osteopenia, non-ambulatory and no reports of a fall or injury according to the documentation and staff.

A telephone interview was completed on 1/25/23 at 1:43 PM with NP #1. She recalled speaking with the ER Physician on 1/18/23 but interpreted their conversation indicated Resident #16's fracture was old, calcified and osteopenia. She stated documented Resident #16's complaints of pain for several days because that was what

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DON #1 and facility staff reported to her. She stated DON #1 and Administrator #1 were notified around the same time when DON #1 called the ER and spoke with an ER Nurse who reported the same interpreted information as she did. NP #1 stated she did not read the ER documentation and was not aware Resident #16 had an acute fracture until she returned from her orthopedic appointment on 1/23/23.

An observation and family interview were conducted on 1/23/23 at 11:18 AM. Resident #16 was sitting up in her wheelchair with a right lower leg immobilizer to her leg. Resident #16 denied pain at this time. The family member stated last week she was notified on 1/18/23 of a possible fracture to Resident #16's right lower leg. She stated Administrator #1 spoke to her and said the fracture diagnosed in the ER on 1/18/23 was an old fracture and that she had not experienced any falls, staff had not reported any injury until 1/18/23 and it was suspected the injury could have happened during routine care from rolling her or transferring her using the mechanical lift. She stated the orthopedic Physician she saw today told her it was not an old fracture but new.
An interview was completed on 1/23/23 at 1:57 PM with Administrator #1. He stated there was no incident report and he was informed by NP #1 or DON #1 that Resident #16's injury was not an acute injury and due to osteopenia. He stated he did not investigate the injury and did not report the injury to the state agency.

On 1/25/23 at 8:33 AM, Administrator #1 provided an investigation dated 1/18/23 which read Resident #16 did not report a recent falls or other injury and interview with her roommate confirmed her statement as accurate. The investigation read

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F 610	Continued From page 36 on 1/24/23 at 10:30 AM, a 24-hour report was sent to the stated due to Resident #16's injury of unknown origin. He confirmed he began his investigation on 1/23/23. An interview was completed on 1/26/23 at 12:16 PM with Administrator #1. He stated the facility should have investigated the injury at the time it was identified on 1/18/23 but due to inconsistencies in what the facility understood and what was documented in the ER report, he did not. He stated he began the investigation after returning from her orthopedic appointment on 1/23/23. A telephone interview was completed on 2/8/23 at 1:30 PM with MD #2. He stated although he could not say for sure, but he felt that the transfer the shower was the "anticipated etiology" for the fracture.	F 610		
F 623 SS=C	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.	F 623		3/17/23

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F 623	Continued From page 37 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, 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;	F 623		

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(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§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:

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F 623	Continued From page 39 Based on record review and interview with the Ombudsman, residents and staff, the facility failed to notify the resident and or responsible party (RP) in writing of the reason for the transfer/discharge to the hospital and failed to send a copy of the discharge notice to the Ombudsman for 3 of 3 sampled residents reviewed for hospitalization (Residents #44, #5 & #50). Findings included: 1. Resident #44 was admitted to the facility on 11/22/22. The admission Minimum Data Set (MDS) assessment dated 12/11/22 indicated that Resident #44's cognition was intact. The nurse's note dated 11/23/22 at 4:48 PM revealed that Resident #44 was transferred to the hospital and was admitted on 11/23/22. The resident was readmitted to the facility on 11/27/22. Review of the nurse's note dated 11/30/22 at 11:20 AM revealed that Resident #44 was transferred to the hospital and was admitted on 11/30/22. The resident was readmitted to the facility on 12/5/22. Resident #44 was interviewed on 1/24/23 at 10:15 AM. He reported that he did not remember receiving a letter from the facility when he was discharged to the hospital in November 2022. 2. Resident 5 was admitted to the facility on 10/27/22.	F 623	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 1. Corrective action for resident(s) affected by the alleged deficient practice: Residents discharged to the hospital for the month of September 2022-December 2022 were included on the discharge listing report and faxed to the Ombudsman by the Social Worker on 01/26/2023. On 02/28/2023, written discharge notices were sent to all residents by the Administrator as they are their own responsible party. Resident #44 was sent written notices for 11/23/2022 and 11/30/2022. Resident #5 was sent a written notice for 11/21/2022. Resident #50 was sent written notices for 9/23/2022 and 10/20/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 01/26/2023, the list of residents discharged to the hospital was reviewed by the Administrator for the months of September 2022 through December 2022	

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F 623	Continued From page 40 The quarterly Minimum Data Set (MDS) assessment dated 11/4/22 indicated that Resident #5's cognition was intact. The nurse's note dated 9/23/22 at 4:29 AM revealed that Resident #5 was transferred to the hospital and was admitted on 9/23/22. The resident was readmitted to the facility on 9/26/22. The nurse's note dated 10/20/22 at 6:26 AM revealed that Resident #5 was transferred to the hospital and was admitted on 10/20/22. The resident was readmitted to the facility on 1/27/22. Resident #5 was interviewed on 1/24/23 at 10:22 AM. She stated that she did not receive any letter from the facility when she was discharged to the hospital. The Social Worker (SW) was interviewed on 1/25/23 at 10:55 AM. The SW stated that she started working at the facility as social worker on October 31, 2022. She stated that she was not aware that she had to send a discharge notice to the Ombudsman when a resident was discharged. She also stated that she was not aware that she had to inform the resident and or the RP in writing of the reason for the discharge when the resident was discharged to the hospital. She reported that nobody had informed her that these (notifying the Ombudsman of discharges and the resident/RP in writing when discharged to the hospital) were her responsibilities. Nurse #6 was interviewed on 1/25/23 at 11:40 AM. She stated that when a resident was transferred/discharged to the hospital, she notified the RP by calling them.	F 623	to monitor that all residents who had been discharged that month, were present on the report that was faxed to the ombudsman on 01/26/2023 by the social worker. Results: There were no residents that were left off the list that was sent on 01/26/2023. The social worker is responsible for giving the resident and/or their responsible party written notices of discharge and for sending all discharged residents to the Ombudsman. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 01/26/2023, the Administrator educated the Social Worker on the requirement to include all residents discharged to the hospital on the list of discharged residents provided to the Ombudsman monthly and on giving the resident or their responsible party a notice of discharge in writing. Contact was made to the local ombudsman and she stated that the discharge report from Point Click Care was sufficient for the monthly report and this is all that she required once at the end of the month. 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 Administrator will monitor compliance utilizing the F623 Quality Assurance Tool for compliance with inclusion of residents	

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F 623	Continued From page 41 The Director of Nursing (DON)#1 was interviewed on 1/25/23 at 11:45 AM. She stated that nursing notified the resident and or the RP verbally when a resident was discharged to the hospital. She added that she had been the unit manager for a while now and she had not notified the resident and or the RP in writing when the resident was discharged to the hospital. The Ombudsman was interviewed on 1/25/23 at 3:05 PM. She stated that recently she had not received any list of discharges from the facility. She reported that the last time she received a list of discharges was on 6/6/22. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that the Social Worker was responsible for notifying the Ombudsman of discharges monthly and in notifying the resident and or the RP in writing when a resident was discharged to the hospital. 3. Resident #50 was admitted on 11/14/22 and transferred to the hospital on 11/22/22 for complaints of chest pain. Review of the medical record did not include any documentation regarding the notice of a bed hold and the Resident #50 did not return to the facility but discharged home from the hospital with family. An interview on 1/25/23 at 10:50 AM with the Business Office Manager. She stated it was the responsibility of the facility Social Worker to send the regional Ombudsman a list of the hospital transfer and discharges.	F 623	discharged to the hospital and faxing of the Discharged Resident Report monthly to the Ombudsman. This will be monitored monthly x 4 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/17/2023	

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F 623	Continued From page 42 An interview was completed on 1/25/23 at 10:55 AM with the Social Worker. She stated she started working at the facility on 10/31/22 and that she was not aware that she had to send the regional Ombudsman a list of hospital transfers and discharges. The SW also stated that she would call the family or responsible party (RP) the following day after a hospital transfer to discuss the bed hold policy and she was not aware of the need to send out a letter to the RP/resident stating the reason for a hospital transfer. An interview was completed on 1/25/23 at 11:40 AM with Nurse #6. She stated she was an agency nurse and had worked at the facility for approximately 2 months. She stated when she transferred a resident to the hospital, she would call the RP and explain the reason or she would explain the reason to an alert and oriented resident. She stated she was not aware that the RP/resident had to be informed in writing of the reason for a hospital transfer. An interview was completed on 1/25/23 at 11:45 AM with Director of Nursing (DON) #1. She stated that the floor nurse informed the RP/resident verbally that the Physician ordered the resident to be sent to the hospital but not aware that a written reason for a hospital transfer was required. A telephone interview was completed on 1/25/23 at 3:05 PM with the regional Ombudsman. She stated the last time she received a list of hospital transfers and discharges from the facility was June 6, 2022.	F 623		
F 626 SS=G	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2)	F 626		3/17/23

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F 626	Continued From page 43 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and Hospital Case Manager, Ombudsman, Business Office	F 626	The statements made on this plan of correction are not an admission to and do	

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F 626	Continued From page 44 Manager, Regional Director, Former Administrator, and current Administrator interviews, the facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital for 1 of 1 resident reviewed for hospital transfer. Resident #106 was medically stable to return on 10/03/22 when the facility refused to readmit the resident. The resident remained in the hospital until 10/26/22 where she expired. Based on the reasonable person concept a resident transferred to the hospital for an acute condition expects to return to their home at the facility following stabilization at the hospital. Refusal to permit the resident's return and the resident's subsequent 23 day stay at the hospital following stabilization would cause a reasonable person to experience a negative psychosocial outcome that would include feelings of anxiety, fear, frustration, and/or a depressed mood. The findings included: Resident #106 was admitted to the facility on 01/25/21. Financial ledger documentation for Resident #106 revealed the following: - On 02/03/21 the Business Office Manager (BOM) switched Resident #106's payor source as private pay. - On 07/27/22 the BOM spoke with Resident #106 about her outstanding bill as she owed over $30,000. The check which Resident #106 provided for the previous two months was returned with non-sufficient funds.	F 626	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. F626 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital. Resident expired during hospital stay. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 02/23/2023, the administrator and corporate clinical nurse completed a 100 % audit of all upcoming discharges and the past 4 months to ensure the resident was allowed to come back to the facility. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Regional Clinical Nurse gave education to the Administrator, Business Office Manager, and Social Services Director on Code of Federal Regulations 483.15, Section E, Paragraphs 1 and 2. All	

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F 626	Continued From page 45 - On 08/10/22 the BOM received another check with non-sufficient funds. She spoke with Resident #106 in which the resident provided her with a credit card. However, the credit card was expired. The BOM told Resident #106 "I did explain to her, that we were probably going to have to issue a 30 Day discharge notice. She said she understood, but has no one to care for her, and she cannot care for herself." The care plan updated on 08/10/22 identified the focus area as Resident #106 preference for discharge was to remain at the facility for long term. The goal included Resident #106 would a have positive adjustment to life at the facility for 90 days, and the facility would continue to meet her needs daily for 90 days. Interventions included the activities department to provide activities that were meaningful to her; family would bring items from home that would help her adjustment; and had care plan meetings with the team quarterly. Financial ledger documentation for Resident #106 indicated on 08/24/22 the BOM went to see Resident #106 about payment. Resident #106 indicated she ordered another debit card from her bank, but had not received it. The BOM indicated she would "give her until Monday morning [8/29/22], and then I am going to proceed with a 30 Day discharge notice. I have attempted to help her with this on several occasions, and to no avail." Review of the Nursing Home Notice of Transfer/Discharge form dated 09/01/22 documented the scheduled discharge date of 10/01/22, for failure, after reasonable and appropriate notice, to pay for (or to have paid	F 626	training was completed by 02/24/2023. 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. Administrator and/or designee are responsible for implementing the acceptable plan of correction. On 2/24/23, the Administrator or designee will monitor compliance utilizing F-tag 626 Permitting Residents to Return to Facility QA tool. Observation will include review of all discharges for 5 residents daily x 4 then weekly x 3, and then monthly x 2. The ongoing auditing program reviewed at the monthly Quality Assurance Meeting until deemed as no longer necessary for compliance with reporting abuse and neglect. Date of Compliance: 03/17/2023	

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under Medicare or Medicaid) a stay at this facility. The Former Administrator (Administrator #2) signed the form on 09/01/22 that documented the discharge was to be Resident #106's home.

Review of the Hearing Request form dated 09/01/22 documented the scheduled discharged of 10/01/22, was unsigned by Resident #106.

There was no evidence in the medical record of discharge planning for Resident #106.

Review of the Skilled Nursing Facility/Nursing Home to Hospital Transfer Form dated 09/29/22 at 11:15 AM indicated Resident #106 was transferred to the hospital due to abnormal lab values.

The quarterly Minimum Data Set (MDS) dated 09/27/22, indicated Resident #106's cognition was intact, and she required total assist of 2 or more staff members for transfers and toilet use as well as extensive assistance of 2 or more staff members staff for bed mobility and dressing. She was not coded as having behaviors or delusions.

The discharge MDS dated 09/29/22 indicated Resident #106's return to the facility was anticipated.

A review of the Hospital Case Manager note dated 10/03/22, the Hospital Case Manager submitted the FL-2 (a form that described a resident's medical condition and the amount of care they need when they entered a facility) to the facility and left messages with the facility to confirm Resident #106 was able to return. The Hospital Case Manager was notified by phone by the BOM and Administrator #2 that Resident #106

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"owes us over $45,000 and our corporate office told us we can't take her back ... 30 day discharge notice was given to patient on 09/01/22 and she did not appeal ... her notice was due on 10/01/22." The Hospital Case Manager asked if Resident #106 had been notified of being unable to return and facility staff stated "no, you have to tell her. She's at your hospital." The note revealed the facility indicated they had not started a Medicaid application because "we know she doesn't meet the criteria because she has a house."

A review of the hospital discharge summary dated 10/26/22 indicated Resident #106 was admitted on 09/29/22 from the facility due to a drop in hemoglobin levels. In the Emergency Department, her blood pressure and potassium levels were low. The low potassium was treated, and she received 3 units of blood. She was stable for discharge on 10/03/22, but "unfortunately she would not be accepted back at Liberty Commons due to reported debts. Her hospitalization was subsequently prolonged awaiting court hearing on 10/24 where the Lee County DSS [Department of Social Services] assumed guardianship since she had no available family." During her hospitalization, she developed severe metabolic acidosis and went into cardiac arrest which required cardiopulmonary resuscitation (CPR) for 20 minutes. The court appointed guardian was called and Resident #106 was made into a Do Not Resuscitate (DNR). Resident #106 went into cardiac arrest again and expired on 10/26/22.

An interview with the Hospital Case Manager on 01/24/23 at 9:46 AM revealed the facility was notified Resident #106 was ready for discharge on 10/03/22. The facility told her they would not

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readmit Resident #106 because "she owes of thousands of dollars." Resident #106 ended up being at the hospital for almost a month until her death. Resident #106 did not have next of kin to act on her behalf; therefore, an application for an emergency court appointed guardian was submitted. Resident #106 was unable to be admitted to another facility because she expired the same day a court appointed guardian was assigned on 10/26/22.

The Business Office Manager (BOM) was interviewed on 01/24/23 at 11:34 AM. She indicated Resident #106 was admitted to the facility for skilled Medicare days and then moved to long-term care as private pay. Resident #106 had a long-term care insurance policy, but her claims were denied. She indicated Resident #106 had stopped paying her bill in May 2022. She stated she had spoken to Resident #106 about non-payment and Resident #106 had indicated she ran out of checks. Resident #106 provided a debit card, but it was expired. She stated she encouraged Resident #106 to call her bank to have them resend a new debit card and more checks. She helped Resident #106 with transferring her mail from her home address to the facility's address so the debit card and checks could be sent to the facility. She stated she did not believe Resident #106 ever spoke to her bank regarding a new debit card or checks, and she did not assist Resident #106 with contacting the bank. She stated she felt like Resident #106 was able to pay, but Resident #106 not having checks available was a barrier. She was instructed by the facility's corporate office to issue a 30-day discharge for non-payment. She explained the 30-day discharge to Resident #106, and she voiced understanding. She stated Resident #106

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was willing to return to her personal residence but did not discuss safe discharge planning. The issue date of the 30-day discharge was 09/01/22 with the scheduled discharge date to be 10/01/22. She indicated Resident #106 was transferred to the hospital on 09/29/22. She stated Administrator #2 told the Hospital Discharge Planner Resident #106 could not return to the facility because a 30-day discharge notice was issued, and they could not take her back.

Administrator #2 was interviewed on 01/24/23 at 2:01 PM by telephone. She indicated the BOM spoke with Resident #106 several times regarding non-payment but the resident had "several excuses" as to why she could not pay. Resident #106 had a change of condition on 09/29/22 and was sent to the hospital for evaluation. She indicated she was instructed by the corporate office that she was not allowed to accept Resident #106 back because of non-payment and they had already issued a 30-day discharge notice. She did not know if safe discharge planning was initiated and stated Resident #106 was going to return to her home.

A telephone interview with the Regional Director on 01/24/23 at 2:30 PM was conducted. He indicated while Resident #106 was at the hospital, the 30-day discharge notice had expired. He stated they do not pause the discharge notice while residents were in the hospital. He further stated the facility made the decision to issue a 30-day notice, but he became aware and was involved in the decision. It is the facility's responsibility to ensure safe discharge planning, and he is not involved with this process.

The Ombudsman was interviewed by telephone

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F 626	Continued From page 50 on 01/25/23 at 3:01 PM. She indicated she was not aware of the circumstances of Resident #106's discharge, but knew she was notified of her discharge. She indicated while it is not a requirement, some facilities involve her when a 30-day discharge notice was given to residents. She further stated the facility should have readmitted Resident #106, and another 30-day discharge notice should have been given to Resident #106. The current Administrator (Administrator #1) was interviewed on 01/26/23 at 9:55 AM. He indicated he had only been at the facility for 2 weeks. He stated his understanding was Resident #106 was issued a 30-day discharge notice on 09/01/22 and went to the hospital on 09/29/22. He indicated he felt the facility gave sufficient notice to Resident #106 regarding the pending discharge for non-payment. He stated the facility gave Resident #106 a 30, 60, and 90 days' notice prior to issuing the 30-day discharge notice. He indicated he felt the discharge was safe due to Resident #106 being admitted to the hospital He stated discharge planning was not needed since Resident #106 was sent to the hospital.	F 626		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of bladder incontinence (Resident #45), pressure	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.	3/17/23

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F 641	Continued From page 51 ulcer (Resident #46) & nutrition (Resident #12) for 3 of 20 sampled residents whose MDS were reviewed. Findings included: 1. Resident #45 was admitted to the facility on 9/22/22 with multiple diagnoses including urinary retention. The quarterly MDS assessment dated 1/8/23 indicated that Resident # 45 had an indwelling urinary catheter and was always incontinent of bladder. Resident #45 had a physician's order on admission (9/22/22) for an indwelling urinary catheter for urinary retention. The MDS Nurse was interviewed on 1/26/23 at 10:42 AM. The MDS Nurse reviewed Resident #45's doctor's orders and verified that the resident had an order for an indwelling urinary catheter on admission and had the urinary catheter during the assessment period (7 sequential days ending on the date of the MDS assessment) of 1/8/23. She indicated that she should have noted Resident #45 as "not rated" for incontinence instead of "always incontinent" because of the indwelling urinary catheter had been present during the assessment. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the MDS assessments to be accurate. 2. Resident # 46 was admitted to the facility on	F 641	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 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 45: Resident Minimum Data Set (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [01/08/2023] was modified. Resident # 46: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) [12/14/2022] was modified. Resident # 12: Resident Minimum Data Set (MDS) assessment (Admission Assessment,) with Assessment /Reference Date (ARD) [01/09/2023] was modified. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents who have indwelling urinary catheters, all current resident who have a wound infection, and all current	

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F 641	Continued From page 52 12/7/22 with multiple diagnoses including pressure ulcers. The admission orders for Resident #46 dated 12/7/22 included ciprofloxacin 500 milligrams (mgs) every 12 hours for an E. coli wound infection. Resident #46 had an order dated 12/8/22 for metronidazole (an antibiotic) 500 mgs - apply to sacral wound bed topically daily. The December 2022 Medication Administration Records (MARs) revealed that Resident #46 had received ciprofloxacin and metronidazole for a wound infection during the assessment period (7 sequential days ending on the date of the MDS assessment) of 12/14/22. The admission MDS assessment dated 12/14/22 indicated that Resident #46 had a stage IV pressure ulcer that was present on admission and had received an antibiotic medication. The assessment did not indicate that Resident #46 had a wound infection during the assessment period. The MDS Nurse was interviewed on 1/26/23 at 10:42 AM. The MDS Nurse reviewed Resident #46's orders and the December 2022 MARs and verified that the resident was admitted and had received antibiotics (ciprofloxacin and metronidazole) for a wound infection during the assessment period (7 sequential days ending on the date of the MDS assessment) of 12/14/22. She stated that she should have noted the wound infection on the admission MDS assessment. Administrator #1 and the Nurse Consultant were	F 641	residents who have elected hospice services have the potential to be affected by the alleged practice. On 2/22/2023, 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 3 current residents with indwelling urinary catheters, 3 out of 6 MDS assessments were modified to reflect accurate data for section H0300: Urinary continence due to inaccuracy. On 2/22/2023, 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 a wound infection identified in the 60day look back period and whose diagnosis status is active in the last 7 days of the ARD have section I2500: wound infection (other than foot) coded accurately. Out of all the current residents, no resident is receiving antibiotic treatment for wound infection. Section 12500: Wound infection (other than foot) is coded accurately for current residents. On 2/22/2023, 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 elected hospice services and whose weight was taken more than 30days prior to the ARD of the assessment have section K0200B: Weight coded accurately. Out of a total 7	

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F 641	Continued From page 53 interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the MDS assessments to be accurate. 3. Resident #12 was originally admitted to the facility on 10/11/21. His diagnoses included severe protein calorie malnutrition, history of a stroke and diabetes type 2. A quarterly Minimum Data Set (MDS) assessment dated 1/9/23 indicated Resident #12's weight was noted as 141 pounds as well as weight loss present. Resident #12's weight data was reviewed and revealed his last recorded weight was 140.8 pounds measured on 7/26/22. No weights had been noted as measured during the MDS assessment look back period (specific time frames for information included in the MDS ending on the assessment date). On 1/24/23 at 2:00 PM, an interview was conducted with the Dietary Manager, who reviewed the MDS assessment dated 1/9/23 as well as the weight data for Resident #12. The Dietary Manager indicated the weight had been noted in error and no weight data should have been entered. During an interview with the Administrator #1 on 1/26/23 at 12:51 PM, he indicated it was his expectation for the MDS assessment to be coded accurately.	F 641	hospice residents, 3 assessments for 3 hospice residents were modified to reflect accurate data for section K0200B: Weight due to inaccuracy. This was completed on 02/22/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/23/2023, 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 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 I2500: wound infection (other than foot). 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	

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F 641	Continued From page 54	F 641	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 discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor□s orders, consults and official diagnostic reports, and other sources as available. If a resident is receiving antibiotic treatment for a wound infection, we shall code Section I2500 wound infection. Section K0200B: Weight. Base weight on the most recent measure in the last 30 days. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment. If the last recorded weight	

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was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again. If the resident□s weight was taken more than once during the preceding month, record the most recent weight. If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident□s medical record. This in service was completed by 02/23/2023. 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 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.

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.

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

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F 641	Continued From page 56	F 641	assessments Admission, Annual or Quarterly Assessment to ensure that Section H0300: Urinary Continence, Section I2500: wound infection (other than foot) and section K0200B: Weight 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, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 03/17/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		3/17/23

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F 656	Continued From page 57	F 656		

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 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 observations, record review and staff

The statements made on this Plan of

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F 656	Continued From page 58 interviews, the facility failed to develop and implement a comprehensive care plan with measurable objectives and interventions in the areas of oxygen therapy and pressure ulcers for 2 of 2 sampled resident (Resident #3 and Resident #16) reviewed for comprehensive care plans. Findings included: 1. Resident #3 was admitted to the facility on 07/02/21 with diagnoses which included a personal history of COVID-19. Review of the quarterly Minimum Data Set (MDS) assessment dated 01/02/23 revealed Resident #3 was cognitively intact. She required extensive assistance with bed mobility, dressing, and toilet use. She was not coded as utilizing oxygen. Review of Resident #3's physician orders dated 01/13/23 revealed supplemental oxygen to be delivered at 2 liters per minute via cannula every shift. Review of Resident #3's care plan last updated on 01/02/23 revealed supplemental oxygen therapy was not included. On 01/23/23 at 10:23 AM an observation of Resident #3 revealed current use of supplemental oxygen via nasal cannula. Another observation on 01/24/23 at 10:40 AM of Resident #3 revealed supplemental oxygen via nasal cannula was in use. An additional observation on 01/25/23 at 9:13 AM of Resident #3 revealed resident to continue to use supplemental oxygen via nasal cannula.	F 656	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. F656 Develop/Implement Comprehensive Care Plan 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #3: Care plan reviewed and revised on 01/26/2023 by interdisciplinary team. Resident has a comprehensive care plan that includes supplemental oxygen therapy. Resident #16: Care plan reviewed and revised on 01/26/2023 by interdisciplinary team. Resident has a comprehensive care plan that includes actual pressure ulcer. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents who use supplemental oxygen and who have actual pressure ulcers/injury have the potential to be affected by the alleged practice. On 2/22/2023, an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all current residents	

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F 656	Continued From page 59 During an interview on 01/26/23 at 10:21 AM with the MDS Nurse revealed an oxygen therapy care plan should have been initiated when the oxygen was order. Not having an oxygen therapy care plan was an oversight. An interview with the Director of Nursing #1 on 01/26/23 at 8:55 AM revealed the MDS Nurse was responsible for updating care plans. The clinical team has a morning meeting that discusses new orders. In the meeting Resident #3's new oxygen order would have been discussed, and the MDS Nurse should have taken note to create a care plan for oxygen therapy. During an interview with Administrator #1 on 01/26/23 at 9:55 AM, he indicated Resident #3 should have had a comprehensive care for supplemental oxygen therapy and care plans should be revised when there were new orders for oxygen therapy. 2. Resident #16 was admitted on 7/24/19 with cumulative diagnoses of Dementia, Congestive Heart failure, Chronic Kidney Disease, Coronary Artery Disease and osteoporosis. Resident #16 was care planned on 9/17/19 and last revised on 10/6/21 for a risk of pressure ulcers but was not care planned for the presence of an actual pressure ulcer that developed on 9/13/22. The quarterly Minimum Data Set (MDS) dated 11/23/22 indicated she was coded for one stage 4 pressure ulcer.	F 656	with orders for supplemental oxygen therapy. Out of a total number 11 residents with supplemental oxygen therapy, 5 did not have oxygen therapy care plan. All current residents with supplemental oxygen therapy have an oxygen therapy care plan in place. This was completed on 02/22/2023. On 2/22/2023, an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all current residents with pressure ulcers/injury. Out of a total number 11 residents with actual pressure ulcers, 0 did not have actual pressure ulcer/injury plan. All current residents with actual pressure ulcer, have an actual pressure ulcer care plan in place. This was completed on 02/22/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/22/2023, The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators 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 develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive	

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F 656	Continued From page 60 An interview was completed on 1/26/23 at 10:21 AM with the MDS Nurse and the Senior Nurse Consultant. She stated she felt it was an oversight, but Resident #16 should have been care planned for the actual pressure ulcer. The Senior Nurse Consultant stated when new orders were received, the expectation was the new orders be reviewed every day to ensure the appropriate care plan was initiated.	F 656	assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be reviewed and implemented for all residents with supplemental oxygen therapy and with actual pressure ulcers/injury. This in service was completed by 02/22/2023. 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. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 656	Continued From page 61	F 656	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 residents with supplemental oxygen therapy and actual pressure ulcers/injury to ensure that care plan is implemented. 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, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 03/17/2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		3/17/23

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F 657	Continued From page 62 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the care plan in the areas of code status (Resident #45) and pressure ulcer (Resident #12) for 2 of 20 sampled residents whose care plans were reviewed. Findings included: 1. Resident # 45 was admitted to the facility on 9/22/22 with multiple diagnoses including malignant neoplasm of the prostate. Resident #45 had a physician's order dated 9/26/22 for cardiopulmonary resuscitation	F 657	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. F657 Care Plan Timing and Revision	

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F 657	Continued From page 63 (CPR)/Full code. Resident #45's advance directives dated 9/22/22 listed as Full code. Resident #45's care plan dated 10/13/22 was reviewed. The care plan problem for the code status was "I have a Do Not Resuscitate (DNR) order that states my wishes for healthcare should I become unable to make decision for myself". The Minimum Data Set (MDS) Nurse was interviewed on 1/26/23 at 10:42 AM. The MDS Nurse reviewed Resident #45's orders and advance directives and verified that the resident's code status was Full code. She stated that the family was back and forth on the resident's code status. She reported that she did not have access to the resident's advance directive, it was kept in the business office, and she missed the order for the Full code. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the care plan to be reviewed and revised as needed. 2. Resident #12 was originally admitted to the facility on 10/11/21. His diagnoses included diabetes type 2 and history of a stroke. The medical record for Resident #12 was reviewed and did not indicate he had received dialysis since admission the facility. Resident #12's active care plan, last reviewed 11/22/22, included a focus area for risk for pressure ulcer development due to decreased sensation related to hemiparesis of the left side. One of the interventions read "observe my skin	F 657	Corrective Action: Resident #45: Care plan reviewed and revised on 01/26/2023 by interdisciplinary team. Resident does not have a care plan for DNR. Resident #12: Care plan reviewed and revised on 01/26/2023 by interdisciplinary team. Resident does not have a care plan for Dialysis Identification of other residents who may be involved with this practice: All current residents with advance directives/code status and who receive dialysis have the potential to be affected by the alleged practice. On 2/22/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all current residents with Do Not Resuscitate orders. Out of a total number 21 residents with Do Not Resuscitate orders, 2 did not have do not resuscitate care plan. All current residents with do not resuscitate orders have a care plan in place. This was completed on 02/22/2023. On 2/22/2023 an audit was completed by Mini Data Set (MDS) Nurse Consultant to review all current residents on dialysis. Out of a total number 3 residents with dialysis, 0 did not have a dialysis care plan. All current residents with dialysis, have an dialysis care plan in place. This was completed on 02/22/2023. Systemic Changes: On 02/23/2023 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by	

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F 657	Continued From page 64 for redness/open areas upon return from dialysis. Inform nurse if any areas noted." On 1/26/23 at 10:22 AM, an interview occurred with the Minimum Data Set (MDS) nurse. After reviewing Resident #12's care plan and medical record she confirmed he had never received dialysis and the intervention was placed on his active care plan in error. The Administrator #1 was interviewed on 1/26/23 at 12:51 PM, and indicated it was his expectation for the care plan to be an accurate representation of the resident.	F 657	Director of Nursing. The education focused on: The facility must develop, implement, review and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident's exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on the residents goals for admission and desired outcomes, the resident's preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must developed, implemented, reviewed and revised upon admission, readmission and with any change in condition. This in service was completed by 02/22/2023. 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	

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F 657	Continued From page 65	F 657	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 Assistant Director of Nursing will observe 5 resident's with code status and dialysis to ensure that care plan is reviewed /revised. 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, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 02/23/2023	
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	F 677		3/17/23

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F 677	Continued From page 66 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #10 and #12) and failed to provide incontinent care (Resident # 46) for 3 of 8 residents reviewed for Activities of Daily Living (ADL's). The findings included: 1. Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included a stroke, muscle weakness and diabetes type 2. A quarterly Minimum Data Set (MDS) assessment dated 1/7/23 indicted Resident #10 had moderately impaired cognition and no behaviors or refusal of care. She required limited to extensive assistance from staff for personal hygiene and bathing tasks. A review of Resident #10's active care plan, last reviewed 1/12/23, included a focus area for ADL self-care performance deficit. One of the interventions included to check nail length and trim and clean as necessary. Report any changes to the nurse. A review of Resident #10's nursing progress notes from 11/1/22 to 1/24/23 revealed no refusals of nail care documented. An observation occurred of Resident #10 on 1/23/23 at 9:31 AM while she was lying in the bed. She was observed with short fingernails to both hands; however, they had a dark substance under them and the right first fingernail was	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 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #10, on 01/26/2023 nail care was provided and documented by the hall nurse. For resident #12, on 1/26/2023 nail care was provided and documented by the hall nurse. For resident # 46, on 01/24/2023 incontinent care was provided and documented by the Certified Nursing Assistant. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/24/2023, the nurse manager began auditing all current residents for the need of nail care. This audit will be completed by 03/06/2023. Nail care was provided to those residents	

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F 677	Continued From page 67 jagged. Resident #10 was observed on 1/24/23 at 8:38 AM while lying in bed. Her nails to both hands remained unchanged from previous observation. On 1/25/23 at 11:00 AM, Resident #10 was observed sitting on the side of her bed. Fingernails to both hands remain with a dark substance under them as well as the right first fingernail was jagged. On 1/25/23 at 11:30 AM, an interview occurred with Nurse Aide (NA) #2 who was familiar with Resident #10. She stated she was not assigned to care for her, but nail care should be rendered on shower days and during personal care if the need was present. She was unable to state why her nail care had not been completed. NA #1 was interviewed on 1/25/23 at 3:28 PM and stated she was assigned to care for Resident #10. She explained nail care should be completed during showers and personal care when there was a need. During an observation of Resident #10's fingernails, the NA confirmed the right first fingernail was jagged and both hands had dark substance under the nails. She added she had not noticed the need during Resident #10's morning care. The Director of Nursing #1 was interviewed on 1/26/23 at 10:00 AM and stated she was not aware of any refusals for nail care from Resident #10 or that nail care was needed. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.	F 677	identified in need of nail care. For current residents, the Certified Nursing Assistants were educated by the nurse manager on 02/24/2023 that nail care is to be provided during daily activities of daily living care and whenever necessary and documented when completed. The nurse is to notified if the resident refuses. This will be completed by 03/06/2023. Beginning on 02/24/2023, the nurse manager began auditing all residents that required incontinent care. This audit was completed on 03/06/2023. Residents requiring incontinent care during the audit incontinent care was provided. For current residents, the Certified Nursing Assistants were educated by the nurse manager on 02/24/2023 that incontinent care is to be provided every 2 hours and when ever necessary. This is to be documented when completed and the nurse notified if the resident refuses. The will be completed 03/06/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/23/2023, the Director of Nursing and/or RN Manager began education to all full time, part time, and PRN Nurses and CNAs on the following: nail care should be performed daily with baths/showers and as needed, incontinent care is to be provided every 2 hours or as needed. Refusal of any care by the resident is to be documented and the nurse notified. This information has been integrated into the standard orientation	

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F 677	Continued From page 68 2. Resident #12 was admitted to the facility on 10/11/21 with diagnoses that included a stroke affecting the left side and diabetes type 2. A review of Resident #12's active care plan, last reviewed 11/22/22, included a focus area for ADL self-care performance deficit related to hemiplegia. One of the interventions included to check nail length and trim and clean as necessary. Report any changes to the nurse. A quarterly Minimum Data Set (MDS) assessment dated 1/9/23 indicated Resident #12 had moderately impaired cognition and required extensive assistance from staff for personal hygiene tasks. A review of Resident #12's nursing progress notes from 11/1/22 to 1/24/23 revealed no refusals of nail care documented. An observation occurred of Resident #12 on 1/23/23 at 10:00 AM while he was lying in bed. He was observed to have long fingernails to both hands with a dark substance under them. Resident #12 stated he didn't like his nails as long as they were. Resident #12 was observed on 1/24/23 at 9:00 AM while lying in bed. Fingernails to both hands remain unchanged from the previous observation. On 1/25/23 at 10:57 AM, Resident #12 was observed lying in bed. Fingernails to both hands remain long with a dark substance underneath them. On 1/25/23 at 11:30 AM, an interview occurred	F 677	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 CNA□s who give residents care in the facility. As of 3/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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 Nursing and/or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The Director of Nursing will nail care compliance and timely incontinent care. 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.	

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with Nurse Aide (NA) #2 who was familiar with Resident #12. She stated she was not assigned to care for him, but nail care should be rendered on shower days and during personal care if the need was present. She was unable to state why his nail care had not been completed.

NA #1 was interviewed on 1/25/23 at 3:28 PM and stated she was assigned to care for Resident #12. She explained nail care should be completed during showers and personal care when there was a need. During an observation of Resident #12's fingernails, the NA confirmed they were long with a dark substance under them and stated she had not noticed the need during Resident #12's morning care.

The Director of Nursing #1 was interviewed on 1/26/23 at 10:00 AM and stated she was not aware of any refusals for nail care from Resident #12 or that nail care was needed. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.

3. Resident #46 was admitted to the facility on 12/7/22 with multiple diagnoses including pressure ulcer. The admission Minimum Data Set (MDS) assessment dated 12/14/22 indicated that Resident #46 had a stage IV pressure ulcer that was present on admission, was always incontinent of bowel and bladder and he needed extensive assistance with personal hygiene. The assessment further indicated that he did not have a behavior of rejection of care.

Resident #46's care plan dated 12/21/22 indicated that he was incontinent of bowel and bladder. The goal was to be free from complications related to bladder incontinence.

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The approaches included to check frequently throughout shift for incontinence and "I wear incontinence briefs at all times and need assistance with all incontinent care".

Resident #46 was observed on 1/24/23 at 9:45 AM during a dressing change. When the Wound Nurse repositioned the resident to his left side, there were 3 cloth pads observed underneath the resident. The Wound Nurse verified that the top pad was soaked with urine. After the dressing change, Nurse Aide (NA) #6 was observed to provide the incontinent care. The resident's disposable brief was also observed soaked with urine.

NA #6 was interviewed on 1/24/23 at 10:01 AM. She stated that she was assigned to Resident #46. She reported that the night shift NA was unable to provide incontinent care to the resident since the resident was combative. She stated that the night shift NA did not specify if incontinent care was not provided on their last round or the entire shift. NA #6 indicated that she tried to check the resident for incontinence this morning, but the resident was combative. She indicated that she had not informed the nurse that the resident was combative. The NA did not explain why she did not inform the nurse.

Nurse #4, assigned to Resident #46, was interviewed on 1/24/23 at 10:15 AM. She stated that NA #6 did not inform her that Resident #46 was combative and refused incontinence care. Nurse #4 reported that she had not known Resident #46 to be combative nor refused care. She stated that she expected the NAs to notify the nurse when the resident refused care or was combative.

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F 677	Continued From page 71 The Director of Nursing (DON) #1 was interviewed on 1/26/23 at 9:31 AM. She stated that she had not known Resident #46 to be combative during care. She indicated that she expected NAs to notify the nurses when a resident was combative or refused care. She expected incontinence checks/care provided at least every 2 hours and as needed. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected NAs to check and to provide incontinence care at least every 2 hours and as needed and to inform the nurses when a resident was combative and refused care. He also indicated that he expected the NA to leave the resident and to come back later when combative and to try other options to ensure care was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and Wound Physician interviews, the facility failed to provide wound care as ordered by the Wound Physician to a diabetic ulcer on the lower	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	3/17/23

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F 684	Continued From page 72 extremity (Resident #10) for 1 of 3 residents reviewed for well-being. The findings included: Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included a stroke, diabetes type 2 with Peripheral Arterial Disease. Review of the Wound Physician's report titled "Wound Evaluation and Management Summary" dated 12/6/22 revealed the right first toe wound measured 2 centimeters (cm) in length and 2.5 cm in width. The order was to apply Skin Prep to the area every shift. Review of the Wound Physician's report titled "Wound Evaluation and Management Summary" dated 12/27/22 revealed the right first toe wound measured 3.5 cm in length and 2.5 cm in width. The order was to apply Skin Prep to the area every shift. The December 2022 Treatment Administration Record (TAR) included an order to apply Skin Prep to the right first toe every shift for wound. A review of the quarterly Minimum Data Set (MDS) assessment dated 1/7/23, indicated Resident #10 had moderately impaired cognition and displayed no behaviors or refusal of care during the look back period. She was coded with diabetic foot ulcers and received pressure reducing devices to the bed/chair and application of dressings to the feet. A review of Resident #10's January 2023 Physician Orders revealed an order, dated 1/8/23, to cleanse the right first toe with wound cleanser	F 684	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. F684 1. Corrective action for resident(s) affected by the alleged deficient practice: On 02/24/2023, the wound treatment nurse completed a wound assessment on Resident #10 to ensure there were no identified change of condition to the wound. On 02/24/2023, the Director of Nursing reviewed resident #10 Treatment Administration Record to ensure that resident wound care on the Treatment Administration Record was transcribed correctly. On 2/24/2023, the Director of Nurses/RN Manager audited resident #10 treatment orders for the last 7 days to assure treatments were documented as administered. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with wound care orders have the potential to be affected by the alleged deficient practice. On 02/24/2023, the Director of Nursing/RN manager reviewed all current wound care orders to ensure they were transcribed accurately on the Treatment Administration Record. This was completed on 0/24/2023. The results	

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F 684	Continued From page 73 and apply Betadine every shift for wound care. A review of the Wound Physician's report titled "Wound Evaluation and Management Summary" dated 1/10/23 revealed the right first toe wound measured 1 cm in length and 2.2 cm in width. The order read to apply Betadine once a day for 30 days. Review of the active care plan, last reviewed 1/12/23, revealed a focus area for having a diabetic ulcer related to diabetes, lack of sensation to the affected area, poor glycemic control, and vascular insufficiency to the right first toe and left and right heel. One of the interventions was to treat the wound as per facility protocol. A review of the Wound Physician's report titled "Wound Evaluation and Management Summary" dated 1/17/23 indicated the right first toe wound measured 1.4 cm in length and 2.4 cm in width. The order read to apply Betadine once a day for 23 days. A review of the January 2023 TAR for Resident #10, did not reveal a change in the treatment order as recommended on 1/10/23 by the Wound Physician. A review of the nursing progress notes from 12/1/22 to 1/25/23 revealed no documented refusals of wound care for Resident #10. On 1/24/23 at 8:38 AM, wound care observation was completed with the Wound Physician and the Wound Nurse. The Wound Nurse was observed removing the gauze wrap from Resident #10's right foot with no redness or odor present. The	F 684	included: no other issues identified. On 02/24/2023, the Director of Nurses/RN Manager reviewed the last 7 days of ordered wound treatments for documentation of completion on the treatment administration record. The results included: no other issues identified. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/24/2023 the Nurse Consultant 0provided in-service education to management nurses (Director of Nursing, RN Manage, minimum data set nurse and Administrator) and beginning on 2/24/2023 the Director of Nurses/RN Manager began education with all licensed nurses, to include agency. Topics included: Treatment Process, Orders are to be transcriber timely and accurately to the Treatment Administration Record, Daily clinical review of all New Wound Care orders to ensure they are transcribed correctly to the Treatment Administration Record/Medication/Treatment Administration, A second Nurse reviews the New wound Care orders are transcriber correctly, Administered treatments are to be documented following completion of the ordered treatment, If a treatment is missed the MD/RP are to be notified and a treatment error report completed, Documentation of administered treatments are to be reviewed in the Daily Clinical Meeting.	

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F 684	Continued From page 74 Wound Physician measured the end of the right first toe at 1.3 cm in length and 2 cm in width. The Wound Nurse cleansed the area, applied Betadine, and wrapped the foot with gauze. The Wound Nurse was interviewed on 1/25/23 at 1:26 PM, who stated that she rounded weekly with the Wound Physician and ensured the orders were correct per the "Wound Evaluation and Management Summary". This summary was received at the facility within 24 hours after the Wound Physician's visit. She reviewed Resident #10's active Physician Orders as well as the "Wound Evaluation and Management Summary" for 12/27/22 and 1/10/23. The Wound Nurse verified the incorrect order was present for the right first toe wound and felt it was an oversight. A phone interview was conducted with the Wound Physician on 1/25/23 at 2:15 PM. She explained she visited the facility once a week to assess and measure wounds for residents that were on her caseload. The Wound Nurse rounded with her where he relayed the measurements as well as any changes to the treatment orders. She stated she thought the nurse was reviewing the treatment orders for accuracy from week to week and expected the facility to follow her recommendations unless the Medical Director changed them. The Wound Physician stated there would have been no negative outcomes to performing the treatments according to the December 2022 TAR. The Director of Nursing #1 was interviewed on 1/26/23 at 10:00 AM and stated she would have expected the Wound Nurse to review and revise the wound orders according to the recommendations by the Wound Physician.	F 684	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive in-service education by 3/17/2023, will not be allowed to work until training been completed. 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 Nursing or designee will monitor the transcription of new wound care orders on the Medication/Treatment documentation during clinical meeting to ensure timely accurate transcription. A second Nurse is to verify the transcription of the new order is accurately transcribed. The F 684 Quality Assurance tool will be completed daily for 4 weeks then monthly for 3months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	

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F 684	Continued From page 75	F 684		
			Date of Compliance: 03/17/2023	
F 686 SS=K	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 Orthopedic Physician Assistant (PA), Wound Nurse, Wound Physician, Medical Director (MD) #2, Director of Nursing (DON) #2, Administrator #2, Nurse Practitioner (NP) #2 and family, the facility failed to prevent the development of a pressure ulcer, protect Resident #16's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint), perform skin checks under the immobilizer and assess skin. At the first orthopedic follow up appointment, an abrasion was identified. Orders were given to pad an abrasion and consult with a wound physician. The orders were not implemented. Skin checks continued not to be done following the identification of the pressure ulcer. The area	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 1. For resident #16, a corrective action was obtained on 2/02/2023 and for residents #12, #45 and #46 corrective action was obtained on 02/24/2023.	3/17/23

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F 686	Continued From page 76 deteriorated to an unstageable pressure ulcer. An unstageable pressure ulcer means a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by eschar (dry, dark scab of dead skin), slough (yellow tissue that is stingy and thick) and granulation tissue (part of the healing process in which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of a wound). Treatments were not performed. The facility failed to assess the wound after 1/17/23 and it re-opened as a stage 4 (deep wound reaching the muscle, ligaments of bone) pressure ulcer on 1/24/23. The facility also failed to provide treatments as ordered for Resident #45 and ensure the alternating air mattress was functioning and set according to manufacturer's instructions for Resident #12 and Resident #46. This deficient practice affected 4 of 4 sampled residents reviewed for pressure ulcers (#16, #12, #45 and #46). Immediate jeopardy began on 9/6/22 when a pressure ulcer on Resident #16's left lateral calf developed underneath a leg immobilizer and the facility failed to implement interventions to prevent worsening of the ulcer. Immediate jeopardy was removed on 2/6/23 when the facility provided and implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the facility completes all staff training and ensure monitoring systems put into place are effective. Examples #2, #3 and #4 were cited at scope and severity of "E".	F 686	Resident #16 received a total body skin assessment on 02/02/2023 by the Interim Director of Nursing (DON). The total body skin assessment revealed that Resident #16 had a current wound on the left lateral calf and a treatment was in place that was being managed by the treatment nurse or the staff nurse according to the physician□s order. On 02/03/2023, the Interim Director of Nurses reviewed Resident #16□s orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. On 01/27/2023, the nursing team verified the resident□s weight and adjusted the alternating pressure reducing air mattress setting accordingly to assure each were set correctly for resident #12 and #46. On 01/24/2023, the assigned nurse completed the ordered treatment for resident #45. 2. 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 02/02/2023, the Interim 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 02/03/23. 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: On 02/02/2023- 02/03/23, the Interim	

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F 686	Continued From page 77 The findings included: 1. Resident #16 was admitted on 7/24/19 with cumulative diagnoses of dementia, congestive heart failure, chronic kidney disease, coronary artery disease and osteoporosis. Resident #16 was care planned on 9/17/19 for a risk of pressure ulcers. This care plan was the active care plan during the survey. Interventions were to assist with frequent position changes and turn for pressure reduction and comfort, float her heels in bed, pressure reducing mattress on the bed, provide incontinence care as needed and report to the nurse immediately of any redness, open areas or irritation to her skin. The quarterly Minimum Data Set (MDS) dated 6/28/22 indicated Resident #16 had severe cognitive impairment, required extensive assistance with bed mobility, transfers and personal hygiene. She was assessed as having no weight loss or weight gain and no pressure ulcers. A nursing note dated 8/17/22 at 5:20 PM read Resident #16 returned from the emergency room on 8/17/22 wearing a left leg immobilizer due to a left distal femur fracture with orders to wear the immobilizer until she was evaluated on 9/6/22 by the orthopedic physician and to check her skin daily to her left lower extremity due to the presence of the leg immobilizer. The electronic medical record (EMR) from 8/17/22 to 8/22/22 did not include any evidence that Resident #16's left lower leg had any skin	F 686	Director of Nurses assessed and audited 100% of all current pressure wounds to assure current wound measurements were completed. The results included: On 2/3/2023, the nurse consultant audited 100% of all residents with identified pressure wounds to assure a current treatment order was correct and in place on the electronic treatment record. The results included: On 2/3/2023 the Interim DON completed a 100% audit of all resident Braden scores for risk for pressure ulcers. The results included: On 2/03/2023, 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: On 03/01/2023, 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 03/01/2023 all residents with ordered alternating pressure reducing air mattresses were in compliance. On 03/01/2023 the Director of Nurses educated the wound nurse on the expectation that alternating pressure reducing mattresses will be set following the manufacturer recommends and the resident□s weight. On 03/01/2023, the DON/RN Manager audited administered documented wound	

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F 686	Continued From page 78 concerns. An orthopedic PA note dated 8/22/22 read Resident #16 was to have daily checks for skin breakdown due to the leg immobilizer. Resident #16's August 2022 Physician orders included an order dated 8/23/22 that read for staff to check her skin for breakdown daily due to immobilizer use on every shift. Resident #16's August 2022 and September 2022 treatment administration records (TAR) revealed staff initials indicating Resident #16's left lower leg under her immobilizer was intact from 9/6/22 through 9/12/22. A telephone interview was completed on 2/2/23 at 2:50 PM with the Wound Nurse. She stated she thought she recalled a blister that popped on 9/6/22 and she just covered it with a sheet of calcium alginate and a dry dressing and assumed the orthopedic Physician would write wound care orders. An orthopedic PA note dated 9/6/22 read there was an observed abrasion to her left lower lateral leg. The orthopedic consult note included orders to pad the area under her immobilizer and consult wound management for wound care orders. A telephone interview was completed on 2/6/23 at 9:00 AM with the Orthopedic PA. He stated on 9/6/22, he observed an area to Resident #16's left lower leg and wrote on his consult note orders to pad the area for protection and to consult the wound provider for wound care orders. A telephone interview was completed on 2/2/23 at	F 686	treatments for compliance the last 3 days. The results included: As of 03/01/2023, all wound treatments were in compliance. 3. Systemic changes Root Cause Analysis was completed on 2/03/2023 with the following staff in attendance: Administrator, Interim Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was done related to staff members lack of daily skin surveillance and thorough skin assessments to identify changes in skin integrity 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: Prevention of avoidable pressure sores. Identification of residents at risk. Provide wound care and dressing changes per physician□s orders. Conduct thorough skin assessments. Review and provide needed treatment from physician referrals regarding identified wounds. Ensure physician□s orders for wound care were followed. On 02/02/2023, the Interim Director of 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	

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F 686	Continued From page 79 2:50 PM with the Wound Nurse. She stated she did not follow up after Resident #16's 9/6/22 appointment for wound care orders. A form titled "Review to Ensure Quality Pressure Injury related to Leg Immobilizer" dated 9/16/22 read wound care orders given at the orthopedic office visit on 9/6/22 were not implemented. The form was initiated by DON #2. The form read Nurse #14 received Resident #16 back from her orthopedic appointment on 9/6/22 and she placed the consult note with wound care orders in the medical records box to be scanned into the electronic medical record (EMR). She stated she read the note but did not recognize that the note included orders to be entered into the EMR and implemented. The facility was unable to provide any contact information for Nurse #14 who was no longer an agency nurse for the facility. A telephone interview was completed on 2/1/23 at 4:50 PM with DON #2. She stated nobody knew about the area discovered at the 9/6/22 orthopedic appointment until on 9/13/22 when a staff member told the Wound Nurse that there was drainage coming from Resident #16's leg immobilizer who consulted with the Wound Physician in the facility at the time. She stated after her investigation it was determined that Nurse #14 did not implement the wound care orders from the 9/6/22 orthopedic consult. The September TAR revealed staff initials indicating Resident #16's left lower leg under her immobilizer was intact from 9/7/22 through 9/12/22.	F 686	to include: The Skin Assessment/Pressure Ulcer Assessment Process to include how to identify when a skin or wound assessment is due to be completed in the electronic health record. 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 02/02/23 education was initiated by the Quality Assurance Nurse Consultants 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 02/02/23, the Quality Assurance Nurse Consultants/ Senior Regional Staff Education Specialist 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 assessment and treatment orders for any new or worsening changes to the skin. On 2/2/2023, the Interim Director of Nurses/Quality Assurance Nurse	

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F 686	Continued From page 80 There were no nursing notes in the electronic medical record from 9/8/22 through 9/12/22 and a nursing note dated 9/13/22 at 12:21 PM read Resident #16's skin was being monitored for irritation to her leg. The daily skin checks under her immobilizer from 9/6/22 through 9/12/22 indicated no concerns. A telephone interview was completed on 2/2/23 at 1:27 PM with Nurse #13. She stated she initialed off on 9/7/22 and 9/12/22 that she completed the skin check under Resident #16's left leg immobilizer when she did not do it. A telephone interview was completed on 2/2/23 at 1:40 PM with Nurse #8. She stated she initialed off that she assessed the skin under Resident #16's leg immobilizer on 9/8/22, 9/10/22 and 9/11/22 but she did not see any open areas. If she had seen any open areas, she would have notified the Charge Nurse or MD #2. A weekly skin assessment completed by Nurse #3 dated 9/9/22 indicated there were no skin abnormalities. A telephone interview was completed on 2/2/23 at 2:37 PM with Nurse #3. She was unable to recall completing Resident #16's weekly skin assessment on 9/9/22 but stated she must not have seen an open area to Resident #16's left lower leg. A telephone interview was completed on 2/2/23 at 2:50 PM with the Wound Nurse. She did not assess the area until 9/13/22 when it was reported that there was drainage noted on her leg immobilizer. A Wound Physician note dated 9/13/22 indicated she was asked to assess Resident #16 for an	F 686	Consultant/Senior Regional Staff Education Specialist began education of all Certified Nursing Assistants, Medication Aides and agency Certified Nursing Assistants on observing the resident□s skin when providing care and timely notification of the nurse regarding noted areas of alterations in skin integrity. The Certified Nursing Assistant education included: what skin integrity concerns are to be reported to the nurse. This includes changes such as odor from a wound/swelling/increased redness/pain/drainage from wound site/new areas of redness or new skin breakdown. As of 2/02/23 the Quality Assurance Nurse Consultants 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 2/5/2023, no Licensed Nurses or	

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F 686	Continued From page 81 unstageable pressure to her left lateral calf on 9/13/22. The assessment revealed Resident #16 had an unstageable pressure ulcer to her left lateral calf with moderate serosanguinous (consisting of both blood and serous fluid) drainage at least 7 days in duration. The note described the wound as measuring 10 centimeters (cm) by 5 cm with 5% of thick adherent black necrotic tissue (eschar) 80% thick adherent devitalized necrotic tissue (slough) and 15% granulation tissue. There was no pain associated with the pressure ulcer. The note read the Wound Physician performed an in-house mechanical debridement (removal of dead, damaged, or infected tissue) of the area with orders to cleanse the left lateral calf with wound cleaner, apply Gentamicin (antibiotic) ointment with Santyl (debriding agent) and to cover it with a calcium alginate (a dressing made from salts of alginic acid obtained from seaweed) dressing and wrap with gauze every day. Resident #16's cumulative Physician orders indicated the Wound Physician's new wound care orders were written on 9/13/22. A telephone interview was completed on 2/3/23 at 8:15 AM with the Wound Physician. She recalled there was redness or the beginning of cellulitis so that's why she started the Gentamycin ointment. She stated the area identified on 9/13/22 to Resident #16's left lateral calf was avoidable and an untreated pressure ulcer could lead to infections and possible osteomyelitis (bone infection). A telephone interview was completed on 2/2/23 at 4:41 PM with MD #2. He stated he thought he	F 686	Certified Nursing Assistants will work without the education/training and competency check off list completed. This is to include agency and new staff. The Interim 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 agency. After 2/05/23 the Interim Director of Nursing 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. 4. 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	

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F 686	Continued From page 82 recalled getting a phone care from the Wound Physician on 9/13/22 to discuss Resident #16's pressure ulcer. He stated Resident #16's pressure ulcer that developed underneath an immobilizer was avoidable and any pressure ulcer that was not treated would deteriorate and could lead to infection, sepsis (blood infection) and possible osteomyelitis. A grievance dated 9/23/22 indicated Resident #16's family member found a dressing to her left lower calf dated 9/20/22. The grievance read the Wound Nurse and floor staff were interviewed and verified the treatment was ordered for daily. The facility began auditing of residents with pressure ulcers for documentation of treatments along with re-education to the nurses to follow the treatment orders frequency as ordered. A form titled "Review to Ensure Quality" completed by DON #2 dated 9/23/22 read Nurse #13 and Nurse #14 documented Resident #16's wound care treatments completed on 9/21/22 and 9/22/22 but the wound care treatment was not provided. The facility was unable to provide any contact information for Nurse #14 why documented she completed Resident #16's stating she was an agency nurse. Resident #16's TARs for September 2022 through October 2022 indicated documented evidence of daily skin checks under her left leg immobilizer until the immobilizer was discontinued on 10/27/22. A Wound Physician note dated 12/6/22 read	F 686	weekly Quality Assurance committee by the Administrator to ensure corrective 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: 03/17/2023	

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Resident #16's left lateral calf pressure ulcer had improved measuring 5.3 cm by 1.3 cm x 0.1 cm with moderate serous drainage with 50% granulation and 50% skin.

A Wound Physician note dated 12/13/22 read Resident #16's left lateral calf pressure ulcer had deteriorated from her last visit on 12/6/22. The area measured 5.5 cm by 2.0 cm by 0.1 cm with moderate serosanguinous drainage with 70% granulation tissue and 30% skin.

Resident #16's new treatment orders dated 12/14/22 were to cleanse her left lateral calf with wound cleaner, apply a Collagen sheet (sheet, pad or gel derived from bovine or porcine collagen), cover with an ABD (a highly absorbent, multilayer, soft, non-woven moisture barrier) pad and secure with gauze wrap every day.

Resident #16's December 2022 treatment administration records (TAR) indicated no documented evidence that her wound care to her left lateral calf was completed on 12/28/22, 12/29/22 and 12/31/22.

An interview on 1/24/23 at 3:00 PM was completed with the Wound Nurse about the lack of wound care documentation on 12/28/22. She confirmed she was assigned Resident #16 on 12/28/22 but stated she did not do the treatment on 12/28/22. She stated she was on a medication cart and the MDS Nurse took over around noon that day and she assumed the MDS Nurse would do the dressing change.

An interview was completed on 1/26/23 at 10:40 AM with the MDS Nurse. She recalled only completing the noon medication pass on 12/28/22

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and she did not complete Resident #16's dressing change. She stated she was relieved by a Medication Aide (MA), and she could not provide treatments to pressure ulcers.

An interview was completed on 1/26/23 at 10:10 AM with Nurse #4. She confirmed she worked with Resident #16 on 12/29/22 and 12/31/22. She reported she did not complete her wound treatments. She stated Nurse #3 relieved her on those days and she did not ask Nurse #3 to complete Resident #16's wound care.

A telephone interview was completed on 1/26/23 at 10:25 AM with Nurse #3. She stated she worked the evening of 12/29/22 and 12/31/22. She stated she was not instructed in report that Resident #16's pressure ulcer care needed to be completed to her left lower calf on 12/29/22 and 12/31/22.

A Wound Physician note dated 1/10/23 read as follows. Resident #16 had a stage 4 pressure ulcer 114 days in duration. The note read the area to her left lateral calf was resolved with the area scabbed. There were new orders to apply a Vaseline or equivalent and cover with a dry dressing daily for one week. Review of Resident #16's January 2023 orders included this order and read to start the new treatment on 1/11/23 for 7 days.

Review of Resident #16's January 2023 treatment orders read a new order dated 1/10/23 for 7 days the staff were to apply a Vaseline dressing and cover with a dry dressing daily through 1/17/23. There were no additional orders for the area after 1/17/23.

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Resident #16's January 2023 TAR indicated documented evidence that her wound care was completed 1/11/23 through 1/16/23 but there was no documented evidence that Resident #16's wound care was completed on 1/17/23.

A telephone interview was completed with Nurse #5 on 2/2/23 11:54 AM. She remembered completing Resident #16's wound care on 1/14/23 and 1/15/23 and recalled the wound as in healing stage. She stated there was no observed drainage, but she did not recall seeing a scab.

A telephone interview was completed on 1/26/23 at 11:40 AM with the Nurse #8. She stated she completed Resident #16's wound care on 1/16/23 but she did not recall exactly how the area looked but stated it must have looked healed since she did not document anything unusual that day.

A telephone call was attempted on 2/2/23 at 12:00 PM to Nurse #12 to inquire why she did not do Resident #16's wound care on 1/17/23 but the voice message mailbox was full.

An observation and family interview were conducted on 1/23/23 at 11:18 AM. Resident #16 was sitting up in her wheelchair and her family member stated she just returned from an appointment with her orthopedic physician. Observed to Resident #16's left lateral calf was a dressing dated 1/16/23. It appeared to have not been changed since 1/16/23 for a total of 7 days. There was old bloody drainage and new bloody drainage observed on and around the old dressing. The family member stated this was not the first time she had found Resident #16's pressure ulcer dressing "days old" and she had brought it to the attention of the facility in the past.

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Resident #16's skin assessment completed by Nurse #3 on 1/21/23 noted an existing skin concern.

A telephone interview was completed on 1/26/23 at 10:05 AM with Nurse #3. She confirmed she completed Resident #16's skin assessment dated 1/21/23. She recalled seeing a dressing to her left lower calf, but she did not notice the date written on the dressing nor did she remove it. When Nurse #3 was informed that at the time of her assessment on 1/21/23, the dressing to Resident #16's left lower calf was 5 days old. She stated the Wound Nurse or Wound Physician would be the ones to assess an open wound.

An interview on 1/23/23 at 3:00 PM was completed with the Wound Nurse. She stated she completed wound rounds with the Wound Physician on Tuesdays. She stated after the order for the Vaseline dressing was completed after 7 days, there were no additional orders since the area was resolved by the Wound Physician on 1/10/23. Arrangements were made for a surveyor observation of the healed area to her left lateral calf on 1/24/23. The Wound Nurse agreed to get surveyor prior to the Wound Physician's assessment was completed on 1/24/23.

An observation was conducted on 1/24/23 at 8:35 AM of Resident #16's left lateral calf. The old dressing previously described dated 1/16/23 was still in place.

An interview was completed on 1/24/23 at 2:50 PM with DON #1. She stated she received a call from the orthopedic office on 1/23/23 who

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reported the dressing on Resident #16's left lower leg dated 1/16/23 appeared to be bleeding and that she told the Wound Nurse to assess it at that time. She stated she would ensure the Wound Nurse followed up with the surveyor regarding the scheduled wound assessment on 1/24/23. She stated it was her expectation that resident wound treatments were administered as ordered and observation be done of a newly healed pressure ulcer due to the increased likelihood it could reopened.

An interview on 1/24/23 at 3:00 PM was completed with the Wound Nurse. She stated after the order for the Vaseline dressing was completed after 7 days, there were no additional orders since the area was resolved by the Wound Physician on 1/10/23. She stated she did not assess Resident #16's left lateral leg after her Vaseline treatment orders were completed. She stated she assumed that the floor nurses would notify her if the area had not resolved or declined when they completed their skin assessments. The Wound Nurse stated she forgot to assess the area reported by the orthopedic office on 1/23/23 but asked the Wound Physician to assess it earlier today. She stated the previously healed pressure ulcer had reopened and was now a stage 4 pressure ulcer again. The Wound Nurse stated she forgot to get the surveyor earlier to observe Resident #16's left lateral calf and that her next wound treatment was not until Thursday 1/26/23.

The Wound Physician note dated 1/24/23 read as follows: Resident #16 was assessed and evaluated for a stage 4 pressure ulcer to her left lateral calf that was at least 1 day in duration. It measured 6.0-centimeter (cm) by 1.5 cm x 0.1

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cm with area of necrotic (dead) tissue and granulated (healing) tissue. The wound was debrided, new treatment orders were given, and the Wound Physician estimated the wound would heal with continued physician evaluation and interventions in 63 days.

A telephone interview was completed on 1/25/23 at 2:15 PM with the Wound Physician. She stated the original onset of the left lateral calf pressure ulcer was from her left leg immobilizer she wore after the left femur fracture in August 2022. The Wound Physician stated there was only a scabbed area near the bottom of her left lateral leg on 1/10/23 and she assumed the facility would have contacted her if on 1/17/23 the area did not appear intact. She stated she was asked by the facility to assess Resident #16's left lateral calf on 1/24/23 and noted the healed pressure ulcer had re-opened and presented with 10% of necrotic tissue and 90% granulation. The Wound Physician stated it was her opinion that resident skin surveillance was a problem at the facility. She stated Resident #16's re-opened area should have been discovered and treated immediately when the facility noted a concern as of 1/23/23. She further stated she expected all of Resident #16's pressure ulcer treatments be administrated as ordered.

A telephone interview was completed on 1/25/23 at 1:43 PM with NP #1 who stated she recently started at the facility the end of December 2022. She stated she was told that Resident #16's pressure ulcer to her left lower calf was resolved but could not recall who told her. She stated the Wound Nurse, and the Wound Physician assessed all pressure ulcers every Tuesday and the Wound Physician wrote her own treatment

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orders. NP #1 stated she did not routinely observe a pressure ulcer unless specifically requested by a nurse. She stated it was her expectation that Resident #16 receive her treatments as ordered and would have expected the area to her left lateral leg be assessed after 1/17/23 when the Vaseline dressing for 7 day was completed to ensure the wound had not reopened or declined since it apparently still was scabbed as of 1/10/23.

A wound care observation of Resident #16's left lateral calf was completed on 1/26/23 at 9:43 AM with the Wound Nurse. There was noted necrotic tissue to the center of the lower, smaller section of the pressure ulcer with pink/red tissue extending higher up on her calf. The Wound Physician stated it was a stage 4 pressure ulcer.

Another wound care observation was completed on 2/2/23 at 10:35 AM with Nurse #1. The old dressing had a small amount of serosanguinous drainage. There was no evidence of redness or infection. The area was improved since previous observation completed on 1/26/23.

Administrator #1 was notified of the immediate jeopardy on 2/3/23 at 10:00 AM.

Administrator #1 provided the following credible allegation for the immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
On 09/06/23 Resident #16 returned from an orthopedic appointment and the transporter gave the nurse the post visit order sheet. The orthopedic MD noted: that a new abrasion was

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noted to the left lateral aspect of the left lower leg. New orders were received for treatment to the area underneath the immobilizer. The orders included that the dressing and padding must be changed daily, and a wound management consult was advised. The nurse placed the after-visit note/order sheet in the medical records box as she had been instructed to do in the past. On 09/13/23 the Certified Nurse Aide was lifting the resident's immobilized leg and felt a wet area on the immobilizer with her hand. On 9/13/23 the resident went to an orthopedic appointment and new orders were received. On 9/13/2023 the wound nurse reviewed the orders and upon assessment of the resident #16 noted a dressing placed by the orthopedic doctor. On 09/13/22 the wound doctor evaluated the left lower leg and noted areas to the left lateral calf and left anterior knee. Treatments were initiated to both left lateral calf stage 4 pressure ulcer and to the unstageable deep tissue injury to the left anterior knee based on the wound physician's assessment and orders.
On 09/15/22 the Director of Nursing completed the Root Cause Analysis. This is an internal process of review to help determine how the wound occurred and what could be done to correct the occurrence or action.
On 1/10/23 the wound doctor assessed the wound and documented that the area was epithelized and had resolved, and that the area presented with a scab. The recommendation was for a Vaseline or equivalent and dry protective dressing for 7 days. The new wound care orders initiated were for a collagen sheet apply once daily x 7days. The dressing dated 1/16/23 was the last day of ordered wound care. The dressing remained in place until noted on 01/23/23. The dressing was removed on 01/23/23 by the wound

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nurse and a new dressing was applied. On 1/24/23 the wound physician assessed the area and noted that a previous stage 4 injury that closed on 1/10/23 had reopened to the left lateral calf and orders were initiated to the wound.
Resident #16 received a total body skin assessment on 02/02/2023 by the Interim Director of Nursing (DON). The total body skin assessment revealed that Resident #16 had a current wound on the left lateral calf and a treatment was in place that was being managed by the treatment nurse or the staff nurse according to the physician's order.
On 02/03/2023, the Interim Director of Nurses reviewed Resident #16's orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds.
On 02/02/2023, the Interim 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 02/03/23. This audit was completed by reviewing 100% of current residents to identify any residents with new pressure wounds or skin integrity alterations.
On 02/02/2023- 02/03/23, the Interim Director of Nurses assessed and audited 100% of all current pressure wounds to assure current wound measurements were completed.
On 2/3/2023, the nurse consultant audited 100% of all residents with identified pressure wounds to assure a current treatment order was correct and in place on the electronic treatment record.
On 2/3/2023 the Interim DON completed a 100% audit of all resident Braden scores for risk for pressure ulcers.
On 2/03/2023, 100% of residents with pressure wounds or at risk for pressure ulcers were

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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.
Root Cause Analysis was completed on 2/03/2023 with the following staff in attendance: Administrator, Interim Director of Nurses, Regional Operations Manager, the Quality Assurance Nurse Consultant and the Medical Director. Root cause analysis was done related to staff members lack of daily skin surveillance and thorough skin assessments to identify changes in skin integrity 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: Prevention of avoidable pressure sores. Identification of residents at risk. Provide wound care and dressing changes per physician's orders. Conduct thorough skin assessments. Review and provide needed treatment from physician referrals regarding identified wounds. Ensure physician's orders for wound care were followed.
Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.
On 02/02/2023, the Interim Director of 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: The Skin Assessment/Pressure Ulcer Assessment Process to include how to identify when a skin or wound assessment is due to be completed in the

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electronic health record. 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 02/02/23 education was initiated by the Quality Assurance Nurse Consultants 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 02/02/23, the Quality Assurance Nurse Consultants/ Senior Regional Staff Education Specialist 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 assessment and treatment orders for any new or worsening changes to the skin.

On 2/2/2023, the Interim Director of Nurses/Quality Assurance Nurse Consultant/Senior Regional Staff Education Specialist began education of all Certified Nursing Assistants, Medication Aides and agency Certified Nursing Assistants on observing the resident's skin when providing care and timely notification of the nurse regarding noted areas of alterations in skin integrity. The Certified Nursing Assistant education included: what skin integrity concerns are to be reported to the nurse. This includes

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changes such as odor from a wound/swelling/increased redness/pain/drainage from wound site/new areas of redness or new skin breakdown.
As of 2/02/23 the Quality Assurance Nurse Consultants 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 2/5/2023, 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 Interim 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 agency.
After 2/05/23 the Interim Director of Nursing will be responsible to ensure Licensed Nurses and Certified Nursing Assistances are educated on the applicable policies and procedures related to skin/wound care and the serious complications

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that might occur for failing to identify and treat a wound in a timely manner.
Alleged date of immediate jeopardy removal 02/06/23.

On 2/7/23, the facility's credible allegation for immediate jeopardy removal was validated by multiple staff interviews including administrative staff were conducted and revealed the facility and agency nurses had in-services on preventive risk assessments, treatment guidelines, inaccurate or false documentation, treatment errors and reviewing consults for new orders. In-servicing was completed with the aides-current and agency on skin concerns and reporting any areas of concern. Care plan of the residents with pressure ulcers or at risk for pressures ulcers were initiated and reviewed. The in-servicing sign in sheets were reviewed for staff signatures.

Immediate jeopardy was removed on 2/6/23.

2) Resident #12 was admitted to the facility on 10/11/21. His diagnoses included severe protein-calorie malnutrition, diabetes type 2 and a stroke with paralysis to the left side.

A review of Resident #12's active care plan, last reviewed 11/22/22, included the following focus areas:
- Risk for pressure ulcer development due to decreased sensation related to left sided hemiparesis (paralysis). The interventions included a pressure reducing mattress to the bed.
- Currently with a pressure ulcer to the right heel and at risk for development of additional pressure ulcers due to decreased ability to re-position and incontinence- resident refusing repositioning. The interventions included air mattress to the bed.

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A quarterly Minimum Data Set (MDS) assessment dated 1/9/23 indicated Resident #12 had moderately impaired cognition, required extensive assistance and had been bed bound for the 7-day assessment period. He was coded with two stage 2 and one unstageable pressure ulcer, as well as having a pressure reducing device to the bed.

A review of Resident #12's medical record from 9/20/22 to 1/17/23 revealed wound care was provided to a sacral and left hip pressure ulcer.

On 1/23/23 at 3:00 PM, an observation was made of Resident #12 while he was lying in the bed. An alternating air mattress machine was hooked to the foot of the bed, however the connection to the mattress was lying on the floor as well as the power plug. Resident #12 was lying on a deflated air mattress.

Another observation was made of Resident #12 on 1/24/23 at 9:00 AM while he was lying in bed. The alternating air mattress machine was not connected to the mattress and the power plug remained on the floor. Resident #12 was lying on a deflated alternating air mattress.

During an observation of Resident #12 the alternating air mattress machine was no longer present at the end of the bed. The deflated air mattress overlay remained under Resident #12 in the bed.

On 1/24/23 at 2:30 PM, an observation of Resident #12 occurred with the Wound Nurse and Nurse Aide (NA) #1. The Wound Nurse verified the alternating air mattress machine was

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no longer in place at the end of the bed and Resident #12 was lying on the deflated air mattress overlay in the bed. NA #1 and the Wound Nurse both recalled the machine being present at the foot of Resident #12's earlier that morning and was not sure what happened to it.

At 3:34 PM on 1/24/23, the Wound Nurse reported the alternating air mattress machine was located in a drawer in Resident #12's room. An observation occurred revealing the alternating air mattress machine was connected to the mattress overlay underneath Resident #12 as well as plugged into power.

A phone interview occurred with the Wound Physician on 1/25/23 at 2:15 PM and stated she would expect the alternating air mattress to be connected and functioning properly as Resident #12 was at high risk for skin breakdown and had a history of pressure ulcers to his sacrum and left hip.

3. Resident #45 was admitted to the facility on 9/22/22 with multiple diagnoses including malignant neoplasm of the prostate. The quarterly Minimum Data Set (MDS) assessment dated 1/8/23 indicated that Resident #45 had 2 stage 3 pressure ulcers and 1 was present on admission.

Resident #45's care plan dated 10/7/22 indicated that he currently had pressure ulcers on his sacrum and left buttock. The goal was for the pressure ulcers to show signs of healing and to remain free from infection. The approaches included to administer treatment as ordered.

Resident #45 had a physician's order dated 1/13/23 to clean the pressure ulcer on the sacrum

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with wound cleanser, apply Medi honey (promotes removal of necrotic tissue) and then calcium alginate (a highly absorbent used for moderate to heavy drainage wounds) and cover with border gauze dressing daily.

On 1/24/23 at 9:20 AM, the facility's Wound Nurse was observed during the dressing change. She reported that Resident #45's pressure ulcer on the left buttock had already been healed. The Wound Nurse was observed to clean the pressure ulcer on the resident's sacrum with a wound cleanser, applied calcium alginate to the wound bed and covered with a dry gauze dressing. She was not observed to apply the Medi honey to the wound.

The Wound Nurse was interviewed on 1/24/23 at 3:31 PM. She reviewed the treatment order for Resident #45's pressure ulcer and verified that the order was to apply Medi honey and calcium alginate to the wound. She confirmed that she only applied calcium alginate to the resident's wound, and she forgot to apply the Medi honey. She explained that the nurses on the floor were responsible for the daily treatment of pressure ulcers. She was responsible for the treatment every Tuesday when the Wound Physician made her wound rounds.

The Wound Physician was interviewed on 1/25/23 at 2:25 PM. She stated that Resident #45's pressure ulcer was unavoidable due to his medical condition, but she expected the nurses to provide the treatment to his pressure ulcer as ordered.

Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The

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F 686	Continued From page 99	F 686		

Administrator stated that he expected nursing to provide treatment to pressure ulcers as ordered.

4. Resident #46 was admitted to the facility on 12/7/22 with multiple diagnoses including pressure ulcer. The admission Minimum Data Set (MDS) assessment dated 12/14/22 indicated that Resident #46 had a stage IV pressure ulcer that was present on admission and his weight was 175 pounds (lbs.).

Resident #46's care plan dated 12/7/22 indicated that he currently had pressure ulcers on his sacrum and right heel. The goal was for the pressure ulcers to show signs of healing and to remain free from infection. The approaches included air mattress to bed.

Review of the electronic weight records revealed that Resident #46's weight on 1/12/23 was 184 lbs.

Resident #46 was observed lying in bed on 1/23/23 at 9:50 AM and on 1/24/23 at 9:45 AM. He was on air mattress and the air mattress machine was set between 200-250 pounds (lbs.). The air mattress machine had setting in lbs. and indicated to set according to the resident's weight per lbs.

The Wound Nurse was interviewed on 1/24/23 at 3:31 PM. She reported that nurses were responsible for checking the air mattress every shift. She stated that Resident #46's air mattress should have been set according to his weight. The Wound Nurse indicated that Resident #46's current weight was 184 lbs., and she checked the resident's air mattress and she verified that it was

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F 686	Continued From page 100 set between 200-250 lbs. She reported that she reset the machine between 150-200 lbs. Nurse #4, assigned to Resident #46, was interviewed on 1/24/23 at 3:32 PM. She stated that she was responsible for checking the air mattress for functioning but not for the weight setting on the machine. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the resident's air mattress to be set according to the resident's weight.	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 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 record review, observations, resident,	F 688	The statements made on this plan of	3/17/23

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F 688	Continued From page 101 staff and Nurse Practitioner interviews, the facility failed to schedule an Orthopedic appointment as ordered (Resident #28) for 1 of 1 resident reviewed for limited range of motion. The findings included: Resident #28 was admitted to the facility on 1/20/21 with diagnoses that included history of a stroke, osteoarthritis, and diabetes type 2. A Nurse Practitioner (NP) progress note dated 9/20/22 indicated resident wished to be seen for finger and hand contractures. Upon assessment he was found to have Dupuytren's contractures to the left first finger, right fourth finger and right fifth finger and requested to be seen further for treatment. The progress note indicated to obtain an orthopedic appointment A Modified Quarterly Minimum Data Set (MDS) assessment dated 10/16/22 indicated Resident #28 was cognitively intact. A review of Resident #28's medical record from 9/20/22 to 1/24/23 did not reveal any orthopedic consult records. On 1/23/23 at 9:45 AM, an interview occurred with Resident #28 and stated he had seen the NP "a few months back" regarding the contractures to his left first finger and the right hand fourth/fifth fingers. Stated he had wanted to be seen by an orthopedic to see what could be done as the contractures are uncomfortable and interfere somewhat with his daily activities. Resident #28 stated he has yet to be seen by an Orthopedic Physician for his finger contractures.	F 688	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. F688 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #28, an Orthopedic Appointment was scheduled for further follow up of the contractures of the left first finger, and the right hand fourth/fifth fingers. This appointment is on 03/06/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/27/2023, the DON/nurse manager audited all current residents who were recommended for follow up appointments. The findings were that there were no other discrepancies with regards to follow up appointments. Any resident that required a follow up appointment has been scheduled by 02/23/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 688	Continued From page 102 The Resident Scheduler was interviewed on 1/25/23 at 11:14 AM and stated there had been no appointments made for Resident #28 to be seen by an Orthopedic Physician. She explained when the Nurse Practitioner or Medical Director ordered a consultation either the Nurse Practitioner or nurses would let her know of the need to schedule the appointment. She was unable to recall receiving the order for consultation from the Nurse Practitioner in September 2022 for Resident #28. A phone interview occurred with NP #3 on 1/26/23 at 11:15 AM, who was familiar with Resident #28. She recalled assessing his finger contractures and his desire to follow-up further with an Orthopedic Physician. She recalled letting the Resident Scheduler know of the need to schedule an appointment with an Orthopedic Physician. NP #3 stated she had been out on medical leave for the past three months and had just returned to the facility this week. She was unable to state why the consultation did not occur but felt Resident #28 should have already had an initial consult with an Orthopedic Physician for his finger contractures. The Director of Nursing #1 was interviewed on 1/26/23 at 10:00 AM and was unable to state why the Orthopedic consultation had not been made in September 2022.	F 688	On. 2/23/2023, the Director of Nursing/RN Manager began in-service education to all full time, part time, and as needed nurses and agency nurses, scheduler and management staff: Topics included: When a resident return from an appointment or is referred by the physician for an appointment the request is to be forwarded to the Director of Nurses. The Director of Nurses will provide the scheduler with the details required to schedule the appointment. It will be scheduled, transportation arrangement will be confirmed and placed on the master facility schedule. The resident and/or RP and MD will be notified of the scheduled appointment. The request will be placed in the resident□s medical record. After the appointment the post visit note will be received by the nurse on the hall, reviewed for orders, orders initiated and the MD/RP notified. The post appointment visit note will be given to the Director of Nurses for review at the Daily Clinical Meeting to assure all needed follow up has been implemented. The post follow up visit note will be placed in the resident□s medical record. 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	

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F 688	Continued From page 103	F 688	who provide residents care in the facility. As of 3/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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/RN Manager will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor scheduled follow up appointments to ensure they are scheduled timely. 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 until deemed no longer necessary for compliance with splint application. The weekly 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: March, 17, 2023	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 104 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to prevent a fall on 8/16/22 for a resident with cognitive impairment and poor decision-making skills who required extensive staff assistance with bed mobility and positioning for 1 (Resident #16) of 8 residents reviewed for accidents. Resident #16's rolled from her side onto the floor resulting in a left femur fracture. The bed was in the high position while Nursing Assistant (NA) #11 left the room to throw dirty linens in the laundry bin outside the resident's room. The findings included: Resident #16 was admitted on 7/24/19 with cumulative diagnoses of Dementia, Congestive Heart failure, Chronic Kidney Disease, Coronary Artery Disease, and osteoporosis. The quarterly Minimum Data Set (MDS) dated 6/28/22 indicated Resident #16 had severe cognitive impairment, required extensive assistance with bed mobility, transfers and personal hygiene. Resident#16 was care planned on 9/11/19 and last revised on 8/16/22 for an actual fall with a risk for further falls. The new intervention of adding grab bars to her bed was implemented on 8/16/22.	F 689	Past noncompliance: no plan of correction required.	

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A nursing note dated 8/16/22 at 2:45 PM read Resident #16 was lying in bed upon entry to the room. The was noted a large red area noted to her right upper lateral thigh and a red are also noted to the inside of her left knee. Resident #16 stated areas were "itchy" when they were touched. The nurse attempted to roll Resident #16 onto her back for asses her further when Resident #16 yelled and grimaced in pain then immediately reached for right thigh. Resident #16 stated she was not in pain until she was moved. Medical Director (MD) #2 was notified of findings and orders for x-rays were given. Orders were given for Tramadol (narcotic pain reliever) 50 milligrams (mg) every 8 hours as needed for pain.

Review of Resident #16's August 2022 medication administration record (MAR) indicated received pain medication on 8/16/22 but not on 8/17/22.

Review of Resident #16's August 2022 orders included an order dated 8/18/22 for Percocet (narcotic pain reliver) every 6 hours while the Tramadol and Naproxen were discontinued.

Another nursing note dated 8/17/22 at 10:11 AM read Resident #16 was assessed and the area noted to right lateral thigh and left medial knee were red blanchable in color. Resident #16 denied any pain, numbness or tingling at this time and she was able to move her extremities at her baseline. The note read the facility was waiting for an x-ray technician to arrive.

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F 689	Continued From page 106	F 689		

Another nursing note dated 8/17/22 at 11:06 AM read due to the delay in obtaining x-rays MD #2 was notified and orders were given to send Resident #16 to the hospital for evaluation.

Review of the ER note dated 8/17/22 read x-rays of the left knee demonstrated a nondisplaced femur fracture, and knee immobilizer was applied to her left leg, Naproxen (nonsteroidal anti-inflammatory drug) 500 mg twice daily for pain as needed pain and to follow up with an orthopedic Physician.

Another nursing note dated 8/17/22 at 5:20 PM read Resident #16 returned from the emergency room (ER) with an immobilizer to her left leg. The report from the ER nurse stated Resident #16 had a fracture to her left distal femur and there were orders to follow up with an orthopedic Physician, leg immobilizer and Naproxen for pain. Resident #16 stated she only experienced pain when her knees were moved.
(There was no documentation stating as to why her pain meds were changed to Percocet, but I imagine they weren't working as well as Percocet

The corrective action for the past non-compliance dated 8/16/22 was as follows: The root cause analysis was determined that NA #11 used poor safety judgement.

The investigation of the incident was reviewed. It read NA #11 began Resident #16's care at 12:30 PM and was in the room for approximately 20 minutes. NA #11 raised the bed to perform care

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to hip height and then stripped the bed linen with Resident #16 still in the bed. NA #11 stated Resident #16 was lying on her back when she collected the linen to put them in the laundry bin outside the of the room. She stated as she was exiting the room when Nurse #13 entered the room. Nurse #13 stated Resident #16 was lying on her back when she raised left leg to cross over her right leg and rolled out of the bed onto the floor. Nurse #13 immediately did a head-to-toe assessment but there was no complaints of pain and no physical evidence of an injury. NA #11 with the assistance of another agency aide (full name unknown) assisted her with the mechanical lift to place Resident #16 in the bed while Nurse #13 called MD #2. At 2:45 PM, MD #2 gave orders for inhouse x-rays to right shoulder, both hips and both knees and the x-ray provider was notified. On 8/17/22 at 7:00 AM, staff education was initiated on bed mobility and at 9:30 AM, it was reported to the DON that the x-ray technician did not come on 8/16/22 so MD #2 was notified, and he gave orders to send Resident #16 to the ER for an evaluation. Resident #16 returned from the ER with a diagnosis of a distal femur periprosthetic fracture with a leg immobilizer to her left leg and orders to follow up with an orthopedic Physician as soon as possible.

A telephone interview was completed on 2/7/23 at 10:45 AM with NA #11. She stated she was completing Resident #16's routine care and recalled removing Resident #16's sheets and rolled her back over onto her back and stepped out to the doorway where the dirty hamper was located. She stated as she was doing that, Nurse #13 walked into the room to put some cream on a rash to her back. NA #11 stated she did not see Resident #16 fall, but she was suspended and

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received re-education.

A telephone interview was completed on 2/7/23 at 1:39 PM with Nurse #13. She stated she got Resident #16's rash cream and went to apply it to her back since NA #11 had her in the bed. She stated when she walked into the room, she observed Resident #16 lying in bed while NA #11stood at the foot of the bed when Resident #16 crossed her legs at the ankles, and she rolled out of the bed. She stated she did a head-to-toe assessment at that time and then NA #11 with another agency aide placed her in the bed using a mechanical lift. She stated Resident #16 did not appear to have any evidence of injuries and did not complain of pain at that time. She recalled re-education at the time of the incident.

Corrective Action That Will Be Accomplished:

There was no apparent injury at the time of the incident at 12:30 PM until DON #2 assessed Resident #16's area of redness to her right thigh and left inner knee. MD #2 ordered Resident #16 be transferred to the ER on the morning on 8/17/22 to rule out any fractures where she was diagnosed with a left distal femur fracture. The care plan was updated on 8/16/22 and orders were given for grab bars to assist in turning and positioning Resident #16 while in bed.

Identification of Other Residents:

On 8/17/22, Director of Nursing (DON) #2 100% audits of all falls that occurred in the previous 14 days was completed to assure that no other residents' incidents were related to bed positioning, mobility or staff error had occurred.

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F 689	Continued From page 109 There were no other incidents identified. On 8/18/22, DON #2 and the MDS Nurse audited all care plans for the presence of bed mobility with the appropriate interventions. The result of the audit included 51 of 53 resident were in compliance with the care planned intervention and as of 8/18/22 100% of all care plans were in compliance for the needed level of assistance with bed mobility. Systemic Changes: DON #2 and DON #1 who was the RN Supervisor at that time began education for all licensed nurse and aides to include agency staff began 8/17/22 at 7:00 AM on bed positioning, mobility, and safe provision of care. Education needed to be completed no later than 8/21/22 or the staff person would not be allowed to work until the training was completed. Quality Assurance: DON #1 was responsible for the ongoing monitoring of bed positioning, mobility and safe provision of care were completed weekly for 2 weeks and monthly for 3 months for the compliance with safe provision of care. The monitoring included observations of 4 aides to include agency aides on various shift to include weekends. Reports were present the quality assurance (QA) committee to ensure compliance and corrective action. A weekly QA meeting would continue to monitor and audit for compliance. The date of compliance was 8/18/22.	F 689		

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F 689	Continued From page 110 As part of the validation process, the plan of correction was reviewed and verified through review of the audit sheet, the in-service records, and staff interviews. Observations were conducted on 2/1/23, 2/2/23, 2/3/23 and 2/7/23 of staff completing care on resident while lying in the bed. There were no observed incidents where staff left a resident unattended of left the bed in the high position prior to leaving the resident's room. Interviews with the staff involved incident dated 8/16/22 were completed and with current staff. Interviews revealed they had received in-serving and education on the provision of safe care with bed mobility and positioning. The validation process verified the facility's date of compliance of 8/18/22.	F 689		
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-	F 690		3/17/23

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F 690	Continued From page 111 (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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and resident and staff interview, the facility failed to secure a urinary catheter to prevent tension or accidental removal for 1 of 2 sampled residents reviewed with indwelling urinary catheters (Resident #45). Findings included: Resident #45 was admitted to the facility on 9/22/22 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 1/8/23 indicated that Resident #45 had an indwelling urinary catheter.	F 690	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. F690 1. Corrective action for resident(s)	

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F 690	Continued From page 112 Resident #45 had a physician order dated 9/23/22 for a strap free securement device which locks the catheter in place and eliminates any chance of a sudden pull and to check the device every day and to change every 7 days and as needed. Resident #45's care plan dated 9/29/22 indicated that he had an indwelling urinary catheter due to urinary retention. The goal was to remain free from catheter related trauma and the approaches included a leg band to secure the catheter. Resident #45 was interviewed on 1/24/23 at 9:18 AM. He stated that he could not tell whether his catheter was secured or not since he was paralyzed from waist down. Resident #45 was observed in bed on 1/24/23 at 9:20 AM during the dressing change. The dressing change was provided by the Wound Nurse. The resident was observed to have an indwelling urinary catheter in place and the catheter tubing was not secured to his thigh. Resident # 45 was again observed up in wheelchair in his room on 1/24/23 at 2:35 PM. NA #7 checked the resident's urinary catheter and verified that there was no securement device. NA #7 was interviewed on 1/24/23 at 2:36 PM. She stated that she transferred the resident from the bed to his wheelchair this morning and noticed that his catheter did not have a securement device. The NA reported that she forgot to report it to the nurse. Nurse # 1, assigned to Resident #45, was interviewed on 1/24/23 at 2:38 PM. She stated that nursing staff including NAs were responsible	F 690	affected by the alleged deficient practice: For resident #45: a leg band was applied on 01/26/23 by the nurse manager. The nurse manager confirmed the task and order for catheter leg band securement was in the resident□s medical record. This was completed on 01/26/23. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 02/27/2023, the nurse manager audited all current residents with Indwelling Urinary Catheters to ensure a securement device was in place. This audit was completed as of 02/27/2023. 3 of 3 residents were noted with an Indwelling Urinary Catheter tubing securement device in place. The resident□s care plan has been updated on 02/27/2023 by the nurse manager. Orders were verified to ensure the securement device is in place by the nurse manager on 02/27/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/27/2023, the Director of Nurses/ RN nurse manager began educating all full time, part time, and prn nurses and CNA□s on the following topics: indwelling urinary catheter care, preventing trauma, and ensuring the Indwelling Urinary Catheter Tubing securement device is in place at all times.	

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F 690	Continued From page 113 for ensuring the resident's urinary catheters were secured and if not, NAs were expected to inform the nurses. Nurse #1 stated that nobody had informed her that Resident #45's urinary catheter did not have a securement device. The Wound Nurse was interviewed on 1/24/23 at 3:28 PM. She stated that she did not notice that Resident #45's urinary catheter was not secured during the dressing change. The Director of Nursing (DON) #1 was interviewed on 1/26/23 at 9:31 AM. She stated that residents with urinary catheter should have their catheters secured to their thigh/leg and nursing was responsible for ensuring that the securement device was in place at all times. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected resident's urinary catheter to be secured at all times.	F 690	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 CNA□s who give residents care in the facility. As of 3/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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 F690 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor to ensure the Foley catheter securement device is in place. 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 until deemed no longer necessary for compliance with foley catheter securement. The weekly QA Meeting is attended by the	

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F 690	Continued From page 114	F 690	Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: March 17, 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 1 sampled residents of oxygen therapy (Resident #3). Additionally, the facility failed to display cautionary signage indicating oxygen in use for 2 of 2 residents observed (Resident #3 and #10). The findings included: 1. Resident #3 was admitted to the facility on 07/02/21 with diagnoses which included a personal history of COVID-19. Review of the quarterly Minimum Data Set (MDS) assessment dated 01/02/23 revealed Resident #3 was cognitively intact. She required extensive	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 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #3, on 01/26/23 the oxygen	3/17/23

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F 695	Continued From page 115 assistance with bed mobility, dressing, and toilet use. She was not coded as utilizing oxygen. Review of Resident #3's physician orders dated 01/13/23 revealed supplemental oxygen to be delivered at 2 liters per minute via cannula every shift. On 01/23/23 at 10:23 AM, Resident #3 was observed lying in the bed receiving humidified oxygen at 1.5 liters per minute via nasal cannula when viewed horizontally, eye level. There was no cautionary signage observed on the door, door frame, or outside the room. On 01/23/23 at 2:46 PM, Resident #3 was observed lying in the bed receiving humidified oxygen at 1.5 liters per minute via nasal cannula when viewed horizontally, eye level. There was no cautionary signage observed on the door, door frame, or outside the room. On 01/24/23 at 10:40 AM Resident #3 was observed lying in the bed receiving humidified oxygen at 1.5 liters per minute via nasal cannula when viewed horizontally, eye level. There was no cautionary signage observed on the door, door frame, or outside the room. On 01/24/23 at 2:42 PM, Resident #3 was observed lying in the bed receiving humidified oxygen at 1.5 liters per minute via nasal cannula when viewed horizontally, eye level. There was no cautionary signage observed on the door, door frame, or outside the room. On 01/25/23 at 9:13 AM, Resident #3 was observed lying in the bed receiving humidified oxygen at 2.5 liters per minute via nasal cannula	F 695	concentrator flow rate was set for 2 liters per minute per the physician orders by the assigned nurse. For resident #3, on 01/26/23 the Oxygen in Use signage was placed on the resident□s door frame by the assigned nurse. For resident # 10, on 01/26/23 the Oxygen in Use signage was placed on the resident□s door frame by the assigned nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 02/27/2023, the RN manager 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. 5 concentrators needed correction. The Oxygen Concentrators were corrected to the correct setting per physician□s order on 02/27/2023. On 02/27/2023, the RN manager completed audit of all current residents receiving Oxygen Therapy to ensure the Oxygen In Use signage is displayed outside the resident□s room who is receiving oxygen therapy. No other concerns were identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/27/2023, the Director of Nurses/ RN Manager began education to all full time, part time, and PRN Nurses (including	

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F 695	Continued From page 116	F 695		

when viewed horizontally, eye level. There was no cautionary signage observed on the door, door frame and outside the room.

An observation was made with Nurse #2 of Resident #3's oxygen concentrator on 01/25/23 at 10:12 AM, who stated the oxygen regulator on the concentrator was set at 2 liters when she viewed it while she stood over the machine. She stated she did not know she needed to view the oxygen regulator on the concentrator at eye level. Then Nurse #2 viewed the oxygen regulator on the concentrator at eye level and adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #2 stated she did not know why the oxygen regulator was set at 2.5 liters. She further stated there should have been a cautionary signage on the door for oxygen in use.

During an interview with the Director of Nursing #1 on 01/26/23 at 08:55 AM, nurses should view the oxygen regulator on the concentrator at eye level to determine if it was set at the correct flow rate. She further stated she expected each resident who was administered oxygen to have a cautionary signage on the outside of the door.

Administrator #1 was interviewed on 01/26/23 at 9:55 AM. He stated physician orders should be followed at the correct oxygen flow rate and all cautionary signage needed to be placed outside of the door for each resident who were on oxygen.
2. Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included congestive heart failure (CHF) and coronary artery disease.

A quarterly Minimum Data Set (MDS) assessment dated 1/7/23 indicated Resident #10

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 must be eye level with the setting screen to ensure it is the correct dose, and Oxygen in Use Signage will be displayed outside the resident□s room who is receiving oxygen therapy.

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 CNA□s who give residents care in the facility. As of 3/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.

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 F695 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The Director of Nursing will

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F 695	Continued From page 117 had moderately impaired cognition (BIMS score of 12) and oxygen was not coded for the resident. A review of the active Physician orders included an order dated 1/11/23 for oxygen at 2 liters per nasal cannula as needed for chest pain or shortness of breath. Resident #10's active care plan, last reviewed 1/12/23, included a focus area for CHF with an intervention to administer oxygen as ordered by the Physician. A review of the January 2023 Medication Administration Record indicated Resident #10 used oxygen at 2 liters via nasal cannula on 1/12/23 and 1/13/23. On 1/23/23 at 9:31 AM, Resident #10 was observed lying in bed. The oxygen concentrator was at the bedside but not in use at the time of the observation. Nasal cannula tubing was attached to the concentrator which was plugged in. There was no oxygen signage anywhere on the door or door frame. Resident #10 was observed lying in bed on 1/24/23 at 8:38 AM and stated she wore oxygen when she felt short of breath. The oxygen concentrator was at the bedside. There was no oxygen signage on the door or door frame of her room. An interview occurred with Nurse #2 on 1/25/23 at 10:12 AM who stated Resident #10 used oxygen as needed for shortness of breath. She verified there was no cautionary signage on the door or door frame and stated there should have been a sign posted for Resident #10's use of oxygen.	F 695	monitor the Oxygen Concentrator flow rate to be accurate and the Oxygen in Use signage is displayed outside the resident□s room where oxygen is in use. 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: March 17, 2023	

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F 695	Continued From page 118 An observation was conducted on 1/25/23 at 11:00 AM, from outside of Resident #10's room, revealing there was no cautionary signage regarding oxygen use on the door or door frame. During an interview with the Director of Nursing #1 on 1/26/23 at 8:55 AM, she indicated that when a resident was ordered oxygen and had a concentrator in their room, a red, magnetic oxygen in use sign was normally placed on the door frame. She was unable to state why this had not occurred for Resident #10.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		3/17/23

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F 756	Continued From page 119 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, Consultant Pharmacist, Nurse Practitioner, and staff interviews, the facility failed to act upon recommendations made by the Consultant Pharmacist for 1 of 6 residents whose medications were reviewed (Resident #12). The findings included: Resident #12 was admitted to the facility on 10/11/21 with diagnoses that included vascular dementia with mood disturbance, congestive heart failure and chronic obstructive pulmonary disease. A review of the active physician orders revealed an order dated 12/16/22 for Ativan (an antianxiety medication) 0.5 milligrams (mg) one tablet by mouth every four hours as needed for anxiety, agitation, shortness of breath. The order was received as a verbal order from Nurse Practitioner (NP) #4.	F 756	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. F756 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident# 12, on 02/09/2023 the physician order was updated to include a 14 day stop date and appropriate clinical indications for use of the psychotropic	

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F 756	Continued From page 120 A review of Resident #12's December 2022 Medication Administration Record (MAR) revealed he received the as needed Ativan on 12/16/22, 12/18/22, 12/21/22, 12/26/22 and 12/31/22. A Pharmacy Medication Regimen Review progress note dated 12/27/22 indicated recommendations were left in a report to the facility. The report indicated a stop date was needed for the as needed Ativan order. This report had not been addressed by a medical practitioner. A review of Resident #12's January 2023 MAR revealed he received a dose of the as needed Ativan on 1/9/23. An interview occurred with the Consultant Pharmacist on 1/24/23 at 2:13 PM. She was able to review her monthly Drug Regimen Review for Resident #12 and stated she had requested a stop date for the as needed Ativan on 12/27/22. The Pharmacist explained recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendation required a practitioner/physician response. A phone interview was conducted with NP #4 on 1/25/23 at 2:30 PM, who stated the former DON would provide her with the pharmacy recommendations that required a response, but she could not recall receiving any for Resident #12. Administrator #1 was interviewed on 1/26/23 at 12:51 PM and explained that the former DON left the facility about a week ago and he had been the	F 756	medications. 2. 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. As of 02/24/2023the Director of Nurses and nursing team began auditing of all pharmacy consultant recommendations for the last 30 days to assure that recommendations made by the pharmacy consultant have been reviewed by the physician and have been implemented as ordered. This will be completed by 02/27/2023. The results included: no other issues identified. As of 02/24/2023, the Director of Nursing and nursing team began auditing the past 30 day PRN psychotropic medications to ensure 14 day stop date. This will be completed by 02/27/2023. The results included: no other issues identified. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 2/23/2023 the Nurse Consultant educated the Director of Nurses and nursing team on the following topics: drug regimen reviews should include an audit of the monthly pharmacy consultant recommendations to assure that they have been addressed by the physician and orders received as a result of recommendations have been implemented timely, drug regimen reviews	

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F 756	Continued From page 121 Administrator for almost three weeks. In addition, the facility acquired a new Medical Director in January 2023. He felt the changeover in staff related to the reason why the recommendation for a stop date had not been addressed. Multiple phone call attempts were made to the DON #2 without success.	F 756	are uploaded to the individual resident documents once all steps in the process have been completed, and psychotropic medications should be reviewed in daily clinical to ensure that all PRN Psychotropic medications have a 14 day stop date. PRN orders for psychotropic 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 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 staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 3/17/2023. 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 F756 Quality Assurance Tool for compliance with the Drug Regimen Review Process weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor for follow through of physician review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by	

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F 756	Continued From page 122	F 756	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. 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: 03/17/2023	
F 758 SS=E	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	F 758		3/17/23

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F 758	Continued From page 123 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 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 resident, staff, Pharmacy Consultant, Psychiatric Nurse Partitioner (NP), NP #1 and NP #2, Director of Nursing (DON) #1 and Medical Director (MD) #2 interviews, observations and record review, the facility failed to attempt a gradual dose reduction (GDR) of a prescribed antipsychotic last increased on 4/21/21(Resident #29). The facility also failed to ensure orders for as needed (PRN) psychotropic (antianxiety) medications had a stop date (Resident #45 and Resident #12) for 3 of 6 residents whose medications were reviewed for unnecessary medications. The findings included:	F 758	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. F758 The facility failed to attempt a gradual	

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F 758	Continued From page 124 1. Resident #29 was admitted on 4/17/19 and readmitted on 5/2/22 with cumulative diagnoses of dementia with mood disturbance, dementia with anxiety, and Parkinson's Disease. Review of the cumulative orders for Resident #29 indicated she was admitted on 4/17/19 on Abilify (an antipsychotic medication) 5 mg daily and increased to 10 mg daily on 4/21/21. There was no documented evidence of a GDR attempt of the Abilify 10 mg dose from 4/21/21 through the review conducted on 1/26/23. Resident #29 was care planned 2/3/21 and revised on 5/9/21 for the use of an antipsychotic medication for anxiety and Parkinson's Disease. Interventions included consulting Pharmacist to review her psychotropic medications quarterly and as needed for possible changes or reductions. Review of Resident #29's January 2023 Physician orders included an order dated 5/27/22 to continue Abilify (antipsychotic) 10 milligrams (mg) daily for depression per psychological services. The annual Minimum Data Set dated 1/17/23 indicated Resident #29 was cognitively intact, exhibited no mood disturbance or behaviors. She was coded for taking an antipsychotic and a Care Area Assessment was completed for psychotropic medication use and addressed the need to evaluate for possible GDR of her psychotropic medications. Review of a Consultant Pharmacist's Medication Regimen Review report sent to Director of Nursing (DON #2) dated 1/25/22 read the	F 758	dose reduction of a prescribed antipsychotic drug for resident #29 and failed to ensure orders for as needed (PRN) psychotropic (antianxiety) medications had a stop date for resident□s #45 and #12. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 29, the clinical indication for the Abilify is depression. On 02/27/2023, the Director of Nursing followed up with the psychiatric nurse practitioner and medical director to discuss pharmacy recommendations for gradual drug reduction of Abilify for resident #29. The plan for gradual drug reduction and clarifications were documented in the resident□s chart by the provider on 03/01/2023. For resident #12, a hospice resident noted with order for as needed (PRN) psychotropic medication without a stop date of 14 days. On 01/25/2023 the Director of Nursing notified the medical provider for clarification orders with corrective actions completed on 02/27/2023. For resident # 45, a hospice resident noted with order for as needed (PRN) psychotropic medication without a stop date of 14 days. On 02/09/2023, the Director of Nursing notified the medical provider for clarifications orders with corrective actions completed on 02/27/2023. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 758	Continued From page 125 recommended to attempt a gradual dose reduction (GDR) of Resident #29's Abilify to ensure the lowest possible dose was effective Review of a Note to Attending Physician/Prescriber recommendation from the Consultant Pharmacist dated 1/25/22 read Resident #29 was prescribed Abilify 10 mgs and a GDR should be considered to ensure she was on the lowest possible effective dose. The documentation on the recommendation read her behaviors were stable but her Abiify was not addressed but did have a GDR completed for 2 other prescribed Antidepressants. This note was signed by MD #2 on 3/1/22. Review of Resident #29's medication administration record's (MAR) for February 2022 to January 26, 2023, indicated Resident #29 received her Abilify daily as ordered. Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 2/24/22 read the Consultant Pharmacist was unable to locate the request from last month for MD #2 to review Resident #29's psychotropic medications for a GDR. Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 3/25/22 read she reviewed the psychiatric NP note dated 3/11/22 and it again made no mention that Resident #29 was taking Abilify or recommendations for a GDR of Abilify. Review of a psychiatric NP progress note dated 4/7/22 did not include any documented evidence that Resident #29 was prescribed Abilify.	F 758	deficient practice. On 02/27/2023, the pharmacy consultant began review of all current residents on anti-psychotic medications for appropriate clinical indication and potential for gradual drug reductions. Any concerns noted will be reviewed with the MD for changes. This process will be completed by 02/27/2023. Results included: no other concerns. On 02/27/2023, the Director of Nursing began audit of the past 30-day pharmacy recommendations to ensure all requested clarifications and follow up concerns have been addressed with the medical provider. This process was completed on 02/27/2023. Results included: no other concerns. On 02/27/2023, the Director of Nursing began auditing all as needed (PRN) psychotropic medications to ensure 14 day stop date. This process was completed on 02/27/2023. Results included: no other concerns. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 2/23/2023 the nurse consultant began educating the Director of Nursing, Minimum Data Set Nurse, Administrator, RN Unit Manager on the pharmacy consultant report process and Residents right to be Free from unnecessary psychotropic medications / PRN use. Education by the Director of Nurses/RN Unit Manager was started on 2/24/2023 with all licensed nurses on	

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F 758	Continued From page 126 Review of a Consultant Pharmacist's Medication Regimen Review report sent to the DON #2 dated 5/27/22 read for the facility to ensure the psychiatric NP was aware the Resident #29 was taking Abilify since there was no mention of it in the most recent psychiatric NP note. Review of a psychiatric NP progress note dated 7/8/22 did not include any documented evidence that Resident #29 was prescribed Abilify. Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 7/26/22 read for the facility to ensure the psychiatric NP was aware the Resident #29 was taking Abilify since there was no mention of it in the most recent psychiatric NP note. Review of a Note to Attending Physician/Prescriber recommendation from the Consultant Pharmacist dated 7/26/22 read Resident #29 was prescribed Abilify 10 mgs and a GDR should be considered to ensure she was on the lowest possible effective dose. This recommendation did not reveal any documented evidence that it was reviewed by MD #2 or the psychiatric NP. Review of a psychiatric NP progress note dated 9/14/22 read a GDR of Resident #29's Abilify had failed and no other documented evidence in the note about the Abilify. Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 9/23/22 read the facility needed to evaluate if Resident #29 was taking Abilify.	F 758	residents right to be Free from unnecessary psychotropic medications / PRN use. 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. As of 3/17/2023, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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 F758 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The Director of Nursing will monitor pharmacy consultant recommendations to ensure timely follow up and clarification and Daily Clinical review of all as needed (PRN) psychotropic medications to ensure 14 day stop date period has been entered. 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 until deemed no longer necessary for compliance unnecessary medications and	

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F 758	Continued From page 127 Review of a Note to Attending Physician/Prescriber recommendation from the Consultant Pharmacist dated 9/26/22 read Resident #29 was prescribed Abilify 10 mgs and a GDR should be considered to ensure she was on the lowest possible effective dose. The documentation on the recommendation indicated NP #2 disagreed because she has had a good response to the current treatment. A GDR was not indicated and wound likely impair Resident #29's function or cause psychiatric instability. This note was signed by the NP #2 on 10/3/22. A telephone interview was completed on 1/26/23 at 11:22 AM with NP #2. She stated she don't recall addressing the Attending Physician/Prescriber recommendation from the Consultant Pharmacist dated 9/26/22 but if she documented on the recommendation that a GDR was not indicated due to the risk of further impairment to Resident #29's function or cause psychiatric instability, that was she intended. Review of a psychiatric NP progress note dated 10/26/22 read a GDR of Resident #29's Abilify had failed, and Resident #29 was tolerating her medication regimen well with no side effects noted. There was no other documented evidence in the note about the Abilify. Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 10/28/22 read for the facility to ensure the MD signed all GDR request for psychotropic medications since the Center's for Medicare and Medicaid Services (CMS) guidelines indicated the primary physician should sign all GDR request that are declined.	F 758	psychotropic medications. 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: 03/17/2023	

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Review of a psychiatric NP progress note dated 11/23/22 read a GDR of Resident #29's Abilify had failed, and Resident #29 was tolerating her medication regimen well with no side effects noted. There was no other documented evidence in the note about the Abilify.

Review of a Consultant Pharmacist's Medication Regimen Review report sent to DON #2 dated 12/27/22 read the facility needed to evaluate if Resident #29 was taking Abilify.

Review of a Note to Attending Physician/Prescriber recommendation from the Consultant Pharmacist dated 12/27/22, read Resident #29 had sustained recent falls and some of her medications may have the possibility of contributing to her increased fall risk. These medications listed for review included her Abilify. The recommendation read NP #1 only agreed to decrease her Amlodipine (lowers blood pressure).

An interview and observation were completed with Resident #29 on 1/23/23 at 9:20 AM. She was dressed for the day, well-groomed and sitting on the side of her bed. She was pleasant, appeared to have a flat affect and restlessness was exhibited by her fidgeting, her hands were constantly moving. She stated she was not having any concerns regarding the care provided by the facility and only voiced some anxiety such as trouble sleeping and concentrating.

Observations were completed on 1/24/23 at 10:27 AM and on 1/25/23 at 12:45 PM of Resident #29 ambulating on the halls.

A telephone interview was completed on 1/25/23 at 2:00 PM with the Consultant Pharmacist. She

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stated she requested GDR attempts or clarifications regarding if the psychiatric NP was aware Resident #29 was prescribed Abilify on 1/25/22, 2/24/22, 3/11/22, 5/27/22, 7/26/22, 9/26/22, 10/28/22 and 12/27/22. She stated there were issues with the facility responding to recommendations and clarifications. She stated she documented the issue numerous times in her monthly Medication Regimen Review report that was sent to DON #2.

A telephone interview was completed on 1/25/23 at 1:43 PM with NP #1. She recalled reviewing the pharmacy recommendation on 12/27/22 regarding Resident #29 sustaining some falls but she had only been working at the facility for a few months and she was not thoroughly up to date on Resident #29's alleged failed GDR attempts because she could only find evidence of GDR refusals by the MD #2 and NP #2

On 1/25/23 at 11:00 AM interviews were completed with Medication Aide (MA) #1, Nursing Assistant (NA) #2 and Nurse #2. They reported the observed behaviors Resident #29 exhibited was impatience, restlessness, excessive ambulating in the halls and involving herself in her roommate's care.

An interview was completed on 1/26/23 at 11:22 AM with NP #2. She stated normally the psychiatric NP would act on pharmacy recommendation regarding psychotropics and was uncertain as to why that did not occur anytime in 2022. She stated Resident #29 should have had a GDR attempt of her Abilify to determine if the dose could be lowered and still effective due to the adverse side effects related to antipsychotics. NP #2 stated she was not aware

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of any GDR refusals, attempts for failures by Resident #29.

A telephone interview was completed on 1/26/23 at 12:24 PM with the psychiatric NP. She stated she spoke to staff, the resident and reviewed the medical record on her visits to the facility. She stated according to the CMS guidance, there should have been an attempted GDR in 2022 but Resident #29 refused to allow her or the facility decrease her Abilify. She stated Resident #29 was alert and oriented and her own responsible party therefore that she would need her to agree. The psychiatric NP stated this was not documented anywhere in her notes but that was why there was no evidence of a GDR attempt on her behalf. She stated it was her understanding from the facility that the MD and NP #2 were aware of her GDR refusals.

An interview was completed on 2/1/23 at 3:24 PM with DON #1 who was the Nurse Supervisor up until 1/13/23. She stated she assisted DON #2 with reviewing the pharmacy Consultant Pharmacist's Medication Regimen Review reports, but she could not offer an explanation as to why the recommendations in the report were not acted upon.

A telephone interview was completed on 2/1/23 at 4:28 PM with DON #2. She stated her last day working as the DON was 1/13/23. She verified receiving a report from the pharmacy every month, but she would enlist the assistance of the Nurse Supervisor or another administrative nurse in reviewing and completing any needed recommendations. She stated she did not go back to ensure all the recommendations were addressed.

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A telephone interview was completed on 2/2/23 at 4:41 PM with MD #2. He stated he was under the impression that Resident #29's Abilify was being reviewed for a possible GDR by the psychiatric NP and a GDR attempt should have been attempted in 2022.

2. Resident #12 was admitted to the facility on 10/11/21 with diagnoses that included vascular dementia, congestive heart failure and chronic obstructive pulmonary disease.

A review of the active physician orders revealed an order dated 12/16/22 for Ativan (an antianxiety medication) 0.5 milligrams (mg) one tablet by mouth every four hours as needed for anxiety, agitation, shortness of breath.

The December 2022 Medication Administration Record (MAR) indicated Resident #12 had received the as needed dosage of Ativan five times.

A quarterly Minimum Data Set (MDS) assessment dated 1/9/23 indicated Resident #12 had moderately impaired cognition and was under Hospice care. Antianxiety medications were not received during the assessment period.

The January 2023 MAR indicated Resident #12 had received the as needed dosage of Ativan one time.

A phone interview was held with Nurse Practitioner #4 on 1/25/23 at 2:30 PM, who stated she was aware of the regulation that required all as needed psychotropic medications to be time

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limited in duration but thought Hospice residents were exempt from the regulation.

On 1/25/23 at 2:33 PM, a phone interview occurred with Nurse #9, who transcribed the verbal order on 12/16/22. She stated she was aware there was a time limited duration for psychotropic medications and felt it was an oversight to not have inquired about a stop date when the order was received on 12/16/22.

The Director of Nursing (DON) #1 was interviewed on 1/26/23 at 10:00 AM and stated she was aware all as needed psychotropic medications required time limited duration even if enrolled in Hospice care, to allow for reassessment of the need for the medication of if any alterations might be needed. DON #1 stated it was the nurses responsibility to obtain a stop date when an order was received for an as needed psychotropic medication.

3. Resident #45 was admitted to the facility on 9/22/22 with multiple diagnoses including anxiety.

Resident #45 had a physician order for hospice consult on 10/4/22 and hospice care was started on 10/8/22.

Resident #45 had a physician order dated 12/6/22 for Lorazepam (an antianxiety medication) 0.5 milligrams (mgs.) - 1 tablet by mouth every 4 hours as needed (PRN) for anxiety/agitation. The order did not include a stop or discontinue date. The order was written by Nurse #7 (hospice nurse).

Review of the Medication Administration Records (MARs) for December 2022 revealed that Resident #45 had received the Lorazepam on

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F 758	Continued From page 133 12/6, 12/8, 12/9, 12/10, 12/11, 12/13, 12/14, 12/15, 12/16, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/25, 12/26, 12/28, and 12/29/22. The MARs for January 2023 revealed that the resident had received the Lorazepam on 1/2, 1/3, 1/4, 1/7, 1/8, 1/10, 1/11, 1/12, 1/13, 1/14, 1/16, 1/17, 1/18, 1/20 and 1/24/23. Nurse #7 was interviewed on 1/25/23 at 9:44 AM. She verified that Resident #45 was under the care of hospice. She also stated that she entered the order for the PRN Lorazepam into the electronic medical records (EMR) for Resident #45. She indicated that she did not know that a stop date is needed when writing orders for PRN psychotropic medications. The Director of Nursing (DON) #1 was interviewed on 1/26/23 at 9:31 AM. She stated that PRN orders for psychotropic medications should have a stop date of 14 days. She indicated that she was not sure though if the stop date of 14 days applied to residents on hospice. Administrator #1 and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected all PRN psychotropic medication orders to have a stop date of 14 days.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		3/17/23

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F 812	Continued From page 134 (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 interview, the facility failed to air dry the insulated plate bases prior to stacking together and ready for use for 44 of 44 insulated plate bases observed. This practice had the potential for cross contamination of food served to residents. Findings included: On 1/24/23 at 11:30 AM, tour of the kitchen was conducted prior to the tray line observation. There were 44 insulated plate bases observed that were stacked together and ready for use at the tray line area. When separated, the plate bases were wet. The Dietary Manager (DM) was informed and observed the wet insulated plate bases. The DM was observed to remove the insulated plate bases that were wet from the tray line area and started drying them with a cloth. On 1/24/23 at 11:50 AM, the DM was interviewed. She stated that she expected the dishes to be air dried and not to stack them when wet. She reported that some of the dishes including	F 812	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. F812 1. Corrective action for resident(s) affected by the alleged deficient practice: On 1/24/2023 Dietary Service Director washed, sanitized, air-dried and properly stacked bases on storage rack when completely dried. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 812	Continued From page 135 insulated plate bases were wet this morning since they were late in washing the dishes and there was not enough time to air dry them before lunch. She reported that 1 dietary aide was sent home and 1 dietary aide came in at 9 AM this morning. The Administrator and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the dishes to be air dried and not to stack them when wet.	F 812	deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 1/24/2023, the Dietary Service Director completed a kitchen walk through to ensure all pots, pans, and small wares had been properly cleaned and stored. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: In-service education was provided to all full time, part time, and as needed staff. Topics included: proper washing, sanitizing, and drying procedures, wet nesting definition and prevention, and inspections on shifts to observe all items properly washed, sanitized, and air dried prior to storage. Dietary Services Director was inserviced by the Administrator on 02/28/2023. Dietary personnel inservice begun on 2/28/2023 by the Dietary Services Director. If dietary employees are not inserviced by 03/03/2023 they will not be scheduled to work until education is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 812	Continued From page 136	F 812	and/or in compliance with regulatory requirements. The Dietary Service Director and/or designee will monitor procedures for proper storage procedures weekly x 4 weeks, then monthly x 3 months, using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all items are washed, sanitized, dried, and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective 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 Date of Compliance: 03/17/2023	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and Administrator #1 and Director of Nursing (DON) #1 interviews the facility administration failed to have effective	F 835	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	3/17/23

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F 835	Continued From page 137 systems in place to prevent, identify, assess, treat, and manage residents with and at risk for pressure sores. This failure resulted in Resident #16 developing an avoidable abrasion under her left leg immobilizer identified on 09/06/22 at an orthopedic consult visit. The abrasion went untreated and area deteriorated into an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) on 9/13/22. The Wound Physician resolved Resident #16's avoidable pressure ulcer on 1/10/23 with an order for 7 days of dressing changes to protect of the healed area. The lack of reassessment after 1/10/23 resulted in the Wound Physician being consulted on 1/24/23 where she observed the area had reopened into a stage 4 pressure ulcer (deep wound reaching the muscle, ligaments of bone) on 1/24/23. This was for 1 of 4 residents reviewed for pressure ulcers (Resident #16). The facility also failed to provide care to a diabetic ulcer as ordered by the Wound Physician for 1 of 3 residents reviewed for care to maintain well-being (Resident #10). Immediate jeopardy began on 9/6/22 when the facility administration failed have effective systems in place to identify and prevent further deterioration of an abrasion on Resident #16's left lateral calf underneath her leg immobilizer. Immediate jeopardy was removed on 2/7/23 when the facility provided and implement an acceptable creditable allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the facility completes all staff training and	F 835	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. F 835 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 received a total body skin assessment on 02/02/2023 by the Interim Director of Nursing (DON). The total body skin assessment revealed that Resident #16 had a current wound on the left lateral calf and a treatment was in place that was being managed by the treatment nurse or the staff nurse according to the physician□s order. On 02/03/2023, the Interim Director of Nurses reviewed Resident #16□s orders and care plan to ensure preventative measures were currently in place to prevent new skin issues and worsening of current wounds. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. On 02/02/2023, the Interim Director of Nurses began identification of residents	

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F 835	Continued From page 138 ensure monitoring systems put into place are effective. Examples #2, #3 and #4 were cited at scope and severity of "E". The findings included: Cross Reference to: F 684: Based on record review, observations, staff and Wound Physician interviews, the facility failed to provide wound care as ordered by the Wound Physician to a diabetic ulcer on the lower extremity (Resident #10) for 1 of 3 residents reviewed for well-being. F 686: Based on record review, observation and interviews with Orthopedic Physician Assistant (PA), Wound Nurse, Wound Physician, Medical Director (MD) #2, Director of Nursing (DON) #2, Administrator #2, Nurse Practitioner (NP) #2 and family, the facility failed to prevent the development of a pressure ulcer, protect Resident #16's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint), perform skin checks under the immobilizer and assess skin. At the first orthopedic follow up appointment, an abrasion was identified. Orders were given to pad an abrasion and consult with a wound physician. The orders were not implemented. Skin checks continued not to be done following the identification of the pressure ulcer. The area deteriorated to an unstageable pressure ulcer. An unstageable pressure ulcer means a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (dead tissue) or eschar (dead tissue). Treatments were not performed. The facility failed to assess the wound after 1/17/23	F 835	that were potentially impacted by this practice by completing total body skin assessments on all current residents on 02/03/23. 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: no other issues identified. On 02/02/2023- 02/03/23, the Interim Director of Nurses assessed and audited 100% of all current pressure wounds to assure current wound measurements were completed. The results included: no other issues identified. On 2/3/2023, the nurse consultant audited 100% of all residents with identified pressure wounds to assure a current treatment order was correct and in place on the electronic treatment record. The results included: no other issues identified. On 2/3/2023 the Interim DON completed a 100% audit of all resident Braden scores for risk for pressure ulcers. The results included: no other issues identified. On 2/03/2023, 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: no other issues identified. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur:	

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F 835	Continued From page 139 and it re-opened as a stage 4(deep wound reaching the muscle, ligaments of bone) pressure ulcer on 1/24/23. The facility also failed to provide treatments as ordered for Resident #45 and ensure the alternating air mattress was functioning and set according to manufacturer's instructions for Resident #12 and Resident #46. This deficient practice affected 4 of 4 sampled residents reviewed for pressure ulcers (#16, #12, #45 and #46). An interview was completed on 2/3/23 at 10:00 AM with Administrator #1. He stated the facility's administration identified a problem with pressure ulcers in the facility the first part of January 2023 but had not had an opportunity to address the concerns. An interview was completed on 2/7/23 at 10:00 AM with Director of Nursing (DON) #1. She stated she started as the DON on 1/13/23 was not aware of the problem with skin surveillance and avoidable pressure ulcers until it was brought to her attention on 1/23/23 by Resident #16's orthopedic Physician follow up visit. Administrator #1 was notified of the immediate jeopardy on 2/3/23 at 10:00 AM. Administrator #1 provided the following credible allegation for the immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance The facility failed to provide leadership and oversight to implement effective systems to identify changes in skin integrity, complete thorough skin assessments, provide treatments as ordered, and manage pressures ulcers.	F 835	On 02/24/2023, the Interim Director of Nurses (DON), RN Unit Manager, LPN Support Nurse, and MDS Nurse were educated by the Quality Assurance Nurse Consultant on the importance for ensuring that all wounds were assessed on a regular basis, referrals to the attending physician and/or wound physician, and efficient oversight of the program. 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 Administrator and/or designee will monitor compliance utilizing the F835 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The Administrator and/or designee will monitor for compliance with F686 Preventing, Treating Pressure Ulcers. Reports will be presented to the weekly Quality Assurance committee by the Administrator and/or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/17/2023	

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In September of 2022, the facility identified a care concern involving Resident # 16. The resident had an orthopedic appointment 9/6/2023 and the physician had ordered care to be provided to an abrasion that was noted under the immobilizer. There was a delay in care, which allowed the wound to worsen due to a lack of monitoring. The facility conducted a root cause analysis with input from the Medical Director as to the cause of the wound and implemented a plan of correction including wound education, looking under the immobilizer, and documentation of skin checks. The Director of Nursing was responsible for monitoring the plan of correction and reporting progress to the Quality Assurance Team.
On 1/10/2023, the wound physician assessed Resident # 16. The wound was resolved, and orders given to apply a protective dressing. On 1/23/2023, noted resident to have a dressing dated 01/16/23 to the left lateral leg with dried blood and new blood. The wound physician reassessed the area on 1/24/2023 and provided a diagnosis of a stage IV presser ulcer.

It was determined that the adverse event response initiated in September 2022 with regards to the wound on the backside of Residents #16 left leg, was completed by the administrative team on 9/28/2022. However, monitoring of this event had not continued or been integrated into the quality assurance processes. Monitoring of pressure ulcers, prevention, identification of risk, providing wound care and dressing changes per physician orders, conducting thorough skin assessments, review of needed treatments from physician referrals regarding identified wounds, and ensuring physician all orders for wound care were followed had not consistently been audited or reported on

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during daily clinical meetings.
All residents have the potential to be affected by the deficient practice.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed
As a part of the root cause analysis, the Corporate Chief Clinical Officer, Director of Clinical Services, Nurse Consultant, Regional Director of Operations, and Administrator conducted a review on 2/3/2023 of the policies for daily clinical and wound prevention and treatment. Based on this review, it was determined that reeducation on the daily clinical process was needed for the Administrator and Interim Director of Nursing. A review was conducted of the tools and work process for alerts with the Administrator and the Interim Director of Nursing. The Regional Clinical Consultant provided this education on 2/3/2023. This included the need for the Administrator and Interim Director of Nursing to use the tools provided by the corporate team for this process. A review of the work process for alerts in the clinical dashboard was also included. No changes were required to the policies. The facility failed to implement and follow through with the policies.
The Regional Operations Director and the Quality Assurance Nurse Consultant will monitor ongoing compliance by attending this daily clinical meeting weekly for a minimum of six months.
Regional Director of Operations and Quality Assurance Nurse Consultant determined on 2/2/2023 that the administrative team completed the adverse event response initiated in September 2022 on 9/28/2022. However, monitoring of this event had not continued nor

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integrated into the quality assurance processes. Monitoring of pressure ulcer prevention, identification of risk, providing wound care and dressing changes per physician orders, conducting thorough skin assessment, review of needed treatments from physician referrals regarding identified wounds, and ensuring physician orders for wound care had not consistently been audited or reported on during daily clinical meetings.

On 2/3/2023, the Interim Director of Nursing and Administrator were educated on the need to adhere to the clinical review meeting objectives which including staying focused on adverse events that require ongoing monitoring have been addressed. The Quality Assurance (QA) Nurse Consultant completed this education on 2/3/2023.

The clinical review meeting is a meeting held at least three times a week. This meeting is attended by the Administrator, Interim Director of Nursing, Wound Nurse, MDS Nurse, Dietary Manager, Social Services Director and Activities Director. During this meeting, the team reviews monitoring of pressure ulcer prevention, identification of risk, providing wound care and dressing changes per physician orders, conducting thorough skin assessment, review of needed treatments from physician referrals regarding identified wounds, and ensuring physician order for wound care. This information will be annotated on a form created specifically for this meeting and will be given to the Medical Director to review and initial. Then this form will be taken to the monthly Quality Assurance meeting to ensure continual compliance with policy.

Additionally, on 2/3/2023 the QA Nurse Consultant reeducated the Interim Director of Nursing and Administrator on the need to review

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during the daily clinical meeting all orders since the previous daily clinical meeting. The Interim Director of Nursing will print the order listing report from the electronic health record by entering a date range and attach it to the daily clinical meeting form. If a dressing has a stop date identified, then the Interim Director of Nursing, Wound Nurse, or MDS Nurse should enter an additional order for the next day to remove the dressing and initial next to the specific order listing identifying it as corrected.
Inter-Disciplinary Team (IDT,) consisting of Interim Director of Nursing, MDS Nurse, Director of Rehabilitation, Dietary Manager, RN Unit Manager, Wound Nurse, and Administrator, in daily clinical meeting should review the alerts dashboard for alerts related to existing pressure ulcers. If an alert for an existing pressure ulcer is identified, then the Interim Director of Nursing, Wound Nurse, or MDS Nurse should review the resident's assessment and chart to ensure that this wound has been previously assessed, is being seen by the Wound Physician, and has a wound care order. The IDT was educated on 2/6/2023 by the QA Nurse Consultant on the new process. This trigger will create an alert on the electronic medical record clinical main alert/overview screen that the IDT reviews as part of the daily clinical meeting whenever a nurse documents a new or existing wound on the skin check user defined assessment. The Interim DON will start the audits on 2/6/23 that focus on direct observation of the nurses accurately performing skin and wound assessments and wound treatments to assure compliance on all shifts to include weekends.
On 2/3/2023, the Regional Director of Operations and the QA Nurse Consultant were onsite to provide supervision of the Interim Director of

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F 835	Continued From page 144 Nursing and Administrator to ensure implementation of this credible allegation and the credible allegation related to F686. This supervision will continue with weekly monitoring to ensure completion of the plans of correction, that the daily clinical process is occurring, timely identification of adverse events, and completed review by the IDT. The Regional Director of Operations and the QA Nurse Consultant will attend the monthly Quality Assurance Committee meetings either in person or remotely to ensure that compliance is being monitored and that adverse events are consistently reviewed during monthly QA. Alleged date of immediate jeopardy removal 02/07/23. On 02/07/23, the facility's credible allegation for Immediate Jeopardy removal effective 02/07/23 was validated by the following: The facility's creditable allegation for immediate jeopardy removal was validated by Administrator #1 and Director of Nursing (DON) #1 interviews and record review. Administrator #1 and DON #1 received re-education and in-serviced on 2/3/23 by the Quality Assurance Nurse Consultant. Policies were reviewed but there were no changes in facility's policies made. The in-servicing sign in sheets were reviewed for administration signatures. Validation of the education of the new process was completed by interviews with the Administrator #1, DON #1 Minimum Data Set (MDS) Nurse and Nurse Practitioner (NP) #1. Immediate jeopardy was removed on 2/7/23.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		3/17/23

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F 842	Continued From page 145 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

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F 842	Continued From page 146 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records for 1 of 1 resident reviewed for diabetic wound care (Resident #10). The findings included: Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included a stroke, diabetes type 2 with peripheral artery disease.	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	

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F 842	Continued From page 147 Resident #10's December 2022 physician orders included to apply Skin Prep to the right first toe every shift for wound. The December 2022 Treatment Administration Record (TAR) was reviewed and revealed the right first toe wound care had not been documented as completed or refused by the resident for the evening shift on 12/8/22, the night shift on 12/8/22 and the day shift on 12/14/22. A quarterly Minimum Data Set (MDS) assessment dated 1/7/23 indicated Resident #10 had moderately impaired cognition, displayed no behaviors or rejection of care, and was coded with diabetic foot ulcers. Review of the January 2023 physician orders included the following wound care: - An order dated 1/8/23 to cleanse the right first toe with wound cleaner and apply Betadine every shift for wound care. - An order dated 1/17/23 to cleanse the left heel with wound cleaner, apply Santyl and protective dressing every day. - An order dated 1/17/23 to cleanse the right heel with wound cleaner, apply Santyl and protective dressing every day. The January 2023 TAR was reviewed and revealed the right first toe and bilateral heel wound care had not been documented as completed or refused by the resident for the day shift on 1/19/23 and the evening shift on 1/21/23. Review of the nursing progress notes from 12/1/22 to 1/24/23 did not reveal any refusals of wound care by Resident #10.	F 842	corrected by the dates indicated. F842 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain accurate medical records for resident #10. On 02/24/2023, the treatment nurse completed a wound assessment on Resident #10 to ensure no identified change of condition. On 02/24/2023, the Director of Nursing reviewed resident #10 Treatment Administration record to ensure resident was receiving ordered care and notification to medical provider and RP of any identified concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered wound treatment have the potential to be affected by the alleged deficient practice. On 02/27/2023, the Director of Nursing began auditing the past 14 days of Treatment Administration Records to ensure treatments were appropriately documented as completed by the assigned nurse. This was completed on 02/27/2023. The results included: no other concerns/issues. On 02/27/2023, the Director of Nursing began assessment of current residents with missed treatment documentation to ensure no changes in wound status. This was completed on 02/27/2023. The results included: no other concerns/issues. 3. Systemic changes:	

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F 842	Continued From page 148 On 1/25/23 at 9:54 AM, an interview occurred with Nurse #1 who was assigned to care for Resident #10 on the day shift of 1/19/23. She reviewed the TAR showing no initial as completing diabetic wound care or refusal by Resident #10 and stated that she completed the wound care as ordered but got busy and forgot to sign the treatments off as completed. A phone interview was completed with Nurse #9 on 1/25/23 at 2:33 PM. She was assigned to care for Resident #10 on the night shift of 12/8/22 and had not initialed the wound care as completed or refused by the resident. Nurse #9 stated she completed the wound care as ordered but forgot to sign the TAR. Nurse #10 was assigned to care for Resident #10 on the evening shift of 12/8/22 and had not initialed the TAR as wound care completed or refused by Resident #10. Nurse #10 was unable to be interviewed. Multiple phone call attempts were made for Nurse #11 but were unsuccessful. Nurse #11 was assigned to Resident #10 on 1/21/23 and had not initialed the evening shift wound care as completed or refused by the resident. The Administrator #1 was interviewed on 1/26/23 at 12:51 PM and indicated it was his expectation for the nursing staff to completed wound care as ordered as well as to document that it was completed or refused by the resident.	F 842	On 02/27/2023, the Director of Nursing began an in-service education to all full time, part time, and as needed RN, LPN, Treatment aide, and wound nurse (including agency). Topics included: Examples of Potential Treatment Errors: " Omission of treatment " Treatment administered without a physician's order " Wrong treatment or medication ordered with treatment is incorrect " Wrong Route Administered " Wrong Time administered " Wrong dose of medication delivered with ordered treatment " Failure to document that the treatment was administered On 02/27/2023, the Nurse Consultant provided an in-service education to management nurses (Director of nursing, support nurse, MDS nurse and Administrator). Topics included: " Daily clinical review of Treatment Administration Record / Medication/Treatment Administration Audit report for missed documentation to ensure timely follow up and immediate corrective actions. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive inservice education by 3/17/2023,will not be allowed to work until training been	

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F 842	Continued From page 149	F 842	completed. 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 Nursing or designee will monitor the completion of Medication/Treatment documentation daily Monday Friday during daily clinical to ensure timely corrective actions and follow up. The F 842 Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of compliance: 03/17/2023	
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	F 867		3/17/23

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F 867	Continued From page 150 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 implementing those actions, measure its success, and track performance to ensure that	F 867		

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F 867	Continued From page 151	F 867		

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 conducted by the facility must reflect the scope and complexity of the facility's services and

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F 867	Continued From page 152 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 review, observations and interviews with the resident, family, staff, Medical Director, Orthopedic Physician Assistant, Wound Physician, Psychiatric Nurse Practitioner, Nurse Practitioners, Consultant Pharmacist, Wound Nurse and Ombudsman, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 2/17/22. This was for 11 deficiencies that were cited in the areas of self-determination (F561), notice	F 867	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.	

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F 867	Continued From page 153 requirements before transfer/discharge (F623), accuracy of assessments (F641), develop/implement comprehensive care plan (F656), care plan timing and revision (F657), Activities of daily Living (ADL) care provided for dependent residents (F677), quality of care (F684), treatment/services to prevent/heal pressure ulcers (F686), free of accident hazards/supervision/devices (F689), administration (F835) and resident records -identifiable information (842) and were recited on the current recertification and CI survey of 2/9/23. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and CI survey conducted on 2/6/20. This was evident for 6 deficiencies that were cited in the areas of increase/prevent decrease in range of motion/mobility (F688), bowel/bladder incontinence, catheter, UTI (F690), respiratory/tracheostomy care and suctioning (F695), drug regimen review, report irregularities (F756), free from unnecessary psychotropic medications/PRN use (F758), and food procurement, store/prepare/serve-sanitary (F812) originally cited on the recertification and CI survey on 2/6/20 and recited on the current recertification and CI survey of 2/9/23. The duplicate citation during the 3 federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program. Findings included: This tag is cross referenced to: F561 - Based on record review, observation and resident and staff interviews, the facility failed to	F 867	F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 2/9/23, the facility□s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 2/17/22. This was for 11deficiencies that were cited in the areas of self-determination (F561), notice requirements before transfer/discharge (F623), accuracy of assessments (F641), develop/implement comprehensive care plan (F656), care plan timing and revision (F657), Activities of daily Living (ADL) care provided for dependent residents (F677), quality of care (F684),treatment/services to prevent/heal pressure ulcers (F686), free of accident hazards/supervision/devices (F689),administration (F835) and resident records -identifiable information (842) and were recited on the current recertification and CI survey of 2/9/23. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and CI survey conducted on 2/6/20. This was evident for 6 deficiencies that were cited in the areas of increase/prevent decrease in range of motion/mobility (F688), bowel/bladder incontinence, catheter, UTI (F690),respiratory/tracheostomy care and suctioning (F695), drug regimen review, report irregularities (F756), free from	

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F 867	Continued From page 154 honor a resident's choice for showers (Resident #10) for 1 of 1 resident reviewed for choices. During the recertification and CI survey of 2/17/22, the facility failed to honor resident's choices related to showers and shampoos for 3 of 4 residents reviewed for choices. F623 - Based on record review and interview with the Ombudsman, residents and staff, the facility failed to notify the resident and or responsible party (RP) in writing of the reason for the transfer/discharge to the hospital and failed to send a copy of the discharge notice to the Ombudsman for 3 of 3 sampled residents reviewed for hospitalization (Residents #44, #5 & #50). During the recertification and CI survey of 2/17/22, the facility failed to notify the responsible party (RP) in writing of the reason for the discharge to the hospital for 4 of 5 residents reviewed for hospitalization. F641 - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of bladder incontinence (Resident #45), pressure ulcer (Resident #46) & nutrition (Resident #12) for 3 of 20 sampled residents whose MDS were reviewed. During the recertification and CI survey of 2/17/22, the facility failed to code the MDS assessments accurately in the areas of nutrition, restraints, dental status, accidents, pressure ulcers and pain management for 7 of 22 residents reviewed.	F 867	unnecessary psychotropic medications/PRN use (F758), and food procurement, store/prepare/serve-sanitary(F812) originally cited on the recertification and CI survey on 2/6/20 and recited on the current recertification and CI survey of 2/9/23. The duplicate citation during the 3 federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: " Corrective action has been taken for the identified concerns in the areas of: self-determination (F561) " Corrective action has been taken for the identified concerns in the areas of: Safe/Clean/Comfortable /Homelike Environment (F584.) " Corrective action has been taken for the identified concerns in the areas of: notice requirements before transfer/discharge (F623) " Corrective action has been taken for the identified concerns in the areas of: accuracy of assessments (F641) " Corrective action has been taken for the identified concerns in the areas of: develop/implement comprehensive care plan (F656) " Corrective action has been taken for the identified concerns in the areas of: care plan timing and revision (F657) " Corrective action has been taken for the identified concerns in the areas of: Activities of daily Living (ADL) care	

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F 867	Continued From page 155 F656 - Based on observations, record review and staff interviews, the facility failed to develop and implement a comprehensive care plan with measurable objectives and interventions in the areas of oxygen therapy and pressure ulcers for 2 of 20 sampled residents (Resident #3 and Resident #16) reviewed for comprehensive care plans. During the recertification and CI survey of 2/17/22, the facility failed to implement care plan intervention after a fall for 1 of 22 residents reviewed. F657 - Based on record review and staff interview, the facility failed to review and revise the care plan in the areas of code status (Resident #45) and pressure ulcer (Resident #12) for 2 of 20 sampled residents whose care plans were reviewed. During the recertification and CI survey of 2/17/22, the facility failed to review and revise the care plan in the areas of medications and pressure ulcers for 2 of 22 residents reviewed. F677 - Based on observation, record review and resident and staff interviews, the facility failed to trim and clean dependent residents' nails (Residents #10 & #12) and failed to provide incontinent care (Resident #46) for 3 of 8 residents reviewed for Activities of daily living (ADL). During the recertification and CI survey of 2/17/22, the facility failed to provide nail care to dependent residents for 5 of 8 residents reviewed for ADL.	F 867	provided for dependent residents (F677) " Corrective action has been taken for the identified concerns in the areas of: quality of care (F684) " Corrective action has been taken for the identified concerns in the areas of: treatment/services to prevent/heal pressure ulcers (F686) " Corrective action has been taken for the identified concerns in the areas of: increase/prevent decrease in range of motion/mobility (F688) " Corrective action has been taken for the identified concerns in the areas of: free of accident hazards/supervision/devices (F689), " Corrective action has been taken for the identified concerns in the areas of: bowel/bladder incontinence, catheter, UTI (F690) " Corrective action has been taken for the identified concerns in the areas of: respiratory/tracheostomy care and suctioning (F695) " Corrective action has been taken for the identified concerns in the areas of: drug regimen review, report irregularities (F756) " Corrective action has been taken for the identified concerns in the areas of: free from unnecessary psychotropic medications/PRN use (F758) " Corrective action has been taken for the identified concerns in the areas of: food procurement, store/prepare/serve-sanitary(F812) " Corrective action has been taken for the identified concerns in the areas of: administration (F835)	

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F 867	Continued From page 156 F684 - Based on record review, observation and staff and Wound Physician interviews, the facility failed to provide wound care as ordered by the Wound Physician to a diabetic ulcer on the lower extremity (Resident #10) for 1 of 3 residents reviewed for well-being. During the recertification and CI survey of 2/17/22, the facility failed to provide the protective skin coverings as ordered and failed to provide treatment to a surgical wound as recommended by the Wound Physician for 2 of 22 residents reviewed for well-being. F686 - Based on record review, observation and interviews with Orthopedic Physician Assistant (PA), Wound Nurse, Wound Physician, Medical Director (MD) #2, Director of Nursing (DON) #2, Administrator #2, Nurse Practitioner (NP) #2 and family, the facility failed to prevent the development of a pressure ulcer, protect Resident #16's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint), perform skin checks under the immobilizer and assess skin. At the first orthopedic follow up appointment, an abrasion was identified. Orders were given to pad an abrasion and consult with a wound physician. The orders were not implemented. Skin checks continued not to be done following the identification of the pressure ulcer. The area deteriorated to an unstageable pressure ulcer. An unstageable pressure ulcer means a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by eschar (dry, dark scab of dead skin), slough (yellow tissue that is stingy and thick) and granulation tissue (part of the healing process in	F 867	" Corrective action has been taken for the identified concerns in the areas of: resident records -identifiable information (842) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 02/09/2023 to review the deficiencies from the January 23 □ February 9, 2023 annual recertification survey, CI survey, and reviewed the citations. On 02/09/2023, the RDO and Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 2/22/23, the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality	

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F 867	Continued From page 157 which lumpy, pink tissue containing new connective tissue and capillaries form around the edges of a wound). Treatments were not performed. The facility failed to assess the wound after 1/17/23 and it re-opened as a stage 4 (deep wound reaching the muscle, ligaments of bone) pressure ulcer on 1/24/23. The facility also failed to provide treatments as ordered for Resident #45 and ensure the alternating air mattress was functioning and set according to manufacturer's instructions for Resident #12 and Resident #46. This deficient practice affected 4 of 4 sampled residents reviewed for pressure ulcers (#16, #12, #45 and #46). During the recertification and CI of 2/17/22, the facility failed to implement an order for a specialty mattress and failed to provide wound care as ordered and as recommended by the Wound Physician for 4 of 6 residents reviewed for pressure ulcers. F688 - Based on record review, observation, resident, staff and Nurse Practitioner interviews, the facility failed to schedule an orthopedic appointment as ordered (Resident #28) for 1 of 1 resident reviewed for limited range of motion. During the recertification and CI survey of 2/6/20, the facility failed to apply the left elbow splint as ordered for 1 of 1 resident reviewed for range of motion. F689 - Based on observations, staff interviews and record review, the facility failed to prevent a fall on 8/16/22 for a resident with cognitive impairment and poor decision-making skills who	F 867	Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/24/2023. 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 Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. 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, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. 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: 03/17/2023	

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required extensive staff assistance with bed mobility and positioning for 1 (Resident #16) of 8 residents reviewed for accidents. Resident #16 rolled from her side onto the floor resulting in a left femur fracture. The bed was in the high position while Nursing Assistant (NA) #11 left the room to throw dirty linens in the laundry bin outside the resident's room.

During the recertification and CI survey of 2/17/22, the facility failed to prevent repeated falls by not providing effective interventions after each fall for 1 of 4 residents reviewed for accidents. The Resident sustained fracture of fingers on 9/10/21 and left and right hip fracture on 9/24/21 after the fall.

F690 - Based on record review, observation and resident and staff interview, the facility failed to secure a urinary catheter to prevent tension or accidental removal for 1 of 2 sampled residents reviewed with indwelling urinary catheters (Resident #45).

During the recertification and CI survey of 2/6/20, the facility failed to secure the indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter use.

F695 - 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 1 sampled residents of oxygen therapy (Resident #3). Additionally, the facility failed to display cautionary signage indicating oxygen in use for 2 of 2 residents observed (Resident #3 and #10).

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During the recertification and CI survey of 2/6/20, the facility failed to administer continuous oxygen at the physician ordered rate for 2 of 2 residents reviewed for respiratory care.

F756 - Based on record review, Consultant Pharmacist, Nurse Practitioner and staff interviews, the facility failed to act upon the recommendations made by the Consultant Pharmacist for 2 of 6 residents whose medications were reviewed (Residents # 12 & #29).

Based on record review, staff and pharmacist interviews, the consultant pharmacist failed to identify incorrect mediation administration route for 1 of 2 residents reviewed for gastric feeding tube.

F758 - Based on resident, staff, Pharmacy Consultant, Psychiatric Nurse Partitioner (NP), NP #1 and NP #2, Director of Nursing (DON) #1 and Medical Director (MD) #2 interviews, observations and record review, the facility failed to attempt a gradual dose reduction (GDR) of a prescribed antipsychotic last increased on 4/21/21(Resident #29). The facility also failed to ensure orders for as needed (PRN) psychotropic (antianxiety) medications had a stop date (Resident #45 and Resident #12) for 3 of 6 residents whose medications were reviewed for unnecessary medications.

During the recertification and CI of 2/6/20, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication for 1 of 4 residents reviewed for

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F 867	Continued From page 160 psychotropic medication use. F812 - Based on observation and staff interview, the facility failed to air dry the insulated plate bases prior to stacking together and ready for use for 44 of 44 insulated plate bases observed. This practice may increase the risks for cross contamination. During the recertification and CI of 2/6/20, the facility failed to discard expired and or spoiled food items in 2 refrigerators and opened and undated food items in the freezer for 3 of 3 food storage, cooling devices observed. F835 -Based on record review and Administrator #1 and Director of Nursing (DON) #1 interviews the facility administration failed to have effective systems in place to prevent, identify, assess, treat, and manage residents with and at risk for pressure sores. This failure resulted in Resident #16 developing an avoidable abrasion under her left leg immobilizer identified on 09/06/22 at an orthopedic consult visit. The abrasion went untreated, and area deteriorated into an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) on 9/13/22. The Wound Physician resolved Resident #16's avoidable pressure ulcer on 1/10/23 with an order for 7 days of dressing changes to protect of the healed area. The lack of reassessment after 1/10/23 resulted in the Wound Physician being consulted on 1/24/23 where she observed the area had reopened into a stage 4 pressure ulcer (deep wound reaching	F 867		

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the muscle, ligaments of bone) on 1/24/23. This was for 1 of 4 residents reviewed for pressure ulcers (Resident #16). The facility also failed to provide care to a diabetic ulcer as ordered by the Wound Physician for 1 of 3 residents reviewed for care to maintain well-being (Resident #10).

During the recertification and CI survey of 2/17/22, the facility administration failed to provide effective oversight to ensure the call system was fully operational.

F842 - Based on record review and staff interviews, the facility failed to maintain accurate medical records for 1 of 1 resident reviewed for diabetic wound care (Resident #10).

During the recertification and CI of 2/17/22, the facility failed to have complete and accurate medical records in the areas of wound care, protective skin coverings, medications, and topical treatment for 3 of 22 residents reviewed.

Interview with Administrator #1 was conducted on 1/26/23 at 12:13 PM. He reported that the facility's failure to implement procedures and monitor the interventions put into place by the QAA committee was due to the turn-over in administration and staff. He added that lack of training, leadership and follow ups contributed to the repeat citations.