STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING _____ B. WING _____	03/31/2023

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ZEBULON REHABILITATION CENTER	509 WEST GANNON AVENUE ZEBULON, NC 27597

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/26/2023 through 3/31/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VR3611.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 3/26/2023 through 3/31/2023. Event ID #VR3611.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		4/27/23

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

Electronically Signed | 04/20/2023

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F 582	Continued From page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services to 1 of 3 residents reviewed for beneficiary protection notification review (Resident #34). The findings included:	F 582	F 582 1. Resident #34 suffered no harm as a result of not being offered a notice of non coverage. Resident #34 is currently in the hospital and will be issued the SNF ABN notice upon return. 2. To identify other residents that have the potential to be affected, the Business Office Manager performed a 30 day look	

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F 582	Continued From page 2 Resident #34 was admitted to the facility on 9/7/22. A review of Resident 34's admission Minimum Data Set (MDS) dated 10/7/22 revealed that she was cognitively intact. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage (NOMNC) letter was issued to Resident #34 which explained Medicare Part A coverage for skilled services would end on 10/26/22 which was signed by Resident #34 on 10/24/22. Resident #34 remained in the facility at the time the survey was being conducted from 3/27/23 through 3/31/23. A review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to Resident #34 or their Responsible Party. On 3/31/23 at 11:25 am an interview was completed with the Business Office Manager (BOM). The BOM confirmed that the CMS-10123 NOMNC was issued when she was notified Resident #34's Medicare Part A coverage for skilled services was ending. The BOM confirmed that neither Resident #34 nor Resident #34's Responsible Party was issued a CMS-10055 SNF-ABN prior to Medicare Part A services ending. The BOM stated that the social worker was responsible for issuing SNF-ABN but that there had not been a social worker employed at the facility when Resident #34's SNF-ABN should have been issued. The BOM stated the SNF-ABN should have been issued because Resident #34 had 50 benefit days remaining. She revealed that she was responsible for issuing SNF-ABN while	F 582	back of all residents who were to receive a notice of SNF ABN and NOMNC to ensure the notice was offered timely and the resident was informed on 4/18/2023. No issues were identified. 3. To prevent this from recurring, the Regional Business Office Manger is conducting an in-service with the Business Office Manager, Administrator and Director of Nursing to provide re-education on SNF ABN and the Non-coverage notification policy. This education will be completed on 4/24/2023. 4. To monitor and maintain ongoing compliance, the Administrator will monitor all non-coverage notices and SNF ABN to ensure they are offered timely and residents are notified. Monitoring will occur 5 x weekly for 12 weeks. 5. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. The QAPI committee includes the Administrator, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Social Worker, Dietary Manager, Infection Control Nurse, Activities Director, Housekeeping Manager, and Maintenance Director. Will be reviewed monthly for 100% compliance for 4 months. Compliance Date 4/27/2023.	

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F 582	Continued From page 3 there was no social worker, but stated that she must have overlooked Resident #34's. An interview was completed with the Administrator on 3/31/23 at 11:28 am. He revealed that when a resident was coming off Medicare Part A services and the resident had days remaining a SNF-ABN should be issued.	F 582		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide facial shaving for residents who required extensive assistance for 2 of 3 residents reviewed for activities of daily living care. (Resident #4 and Resident #24) The findings included: 1.Resident #4 was originally admitted to the facility on 12/10/18, with diagnoses that included Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Multiple Sclerosis (MS). Resident had history of recurrent hospital admission. Resident #4's care plan revised on 10/24/22 showed a focus for Activities of Daily Living (ADL) self-care performance deficit due to decreased strengthening and activity intolerance. Interventions included 1 person assistance with	F 677	F677 1. Resident # 4 was sent out to the hospital due to a change in condition on 3/29/2023. Resident # 24 was provided shaving by the certified nursing assistant on 3/30/2023. 2. To identify other residents that have the potential to be affected, an audit of all female and male residents was performed by the Unit Manager/designee on 4/21/2023 to determine if facial hair was present. Shaving was provided by the certified nursing assistant on those residents who agreed to be shaved. 3.To prevent this from-recurring the Director of Nursing/designee reeducated all licensed staff that personal care including shaving of facial hair on all	4/27/23

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F 677	Continued From page 4 personal hygiene. Resident #4's quarterly Minimum Data Set (MDS) dated 02/27/23 revealed she was cognitively intact with no rejection/refusal of care or behaviors. Resident #4 required extensive assistance with personal hygiene. An observation of Resident #4 on 03/27/23 at 10:00 AM revealed there was facial hair on her chin and upper lip that was approximately ½ to ¾ inches long. During an observation and interview of Resident #4 on 03/28/23 at 10:06 AM the facial hair to her upper lip and chin was still visible and approximately ½ to ¾ inches long. Resident #4 shared that her face was shaved every 2 or 3 weeks, but she did not want the hair on her face and she was not always asked to be shaved during care. Resident #4 reported that if it was her choice, she would not have the facial hair. Resident #4 was unable to recall the last time she had been shaved. Review of the medical record indicated Resident #4 was sent out of the facility on 03/29/23 to the hospital. An interview on 03/30/23 at 10:25 AM with Nurse Aide #6 (NA) revealed she had cared for Resident #4 on the 7:00 AM - 3:00 PM shift on 03/28/23. NA #6 said she did not notice the facial hair during daily care. NA #6 reported that a resident could be shaved even if it was not a shower day. NA #6 revealed that she usually worked with Resident #4 and could not recall the Resident refusing care	F 677	residents will be offered as the resident allows. This education was completed on 4/11/2023. Any licensed staff that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/designee. 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will monitor personal care including shaving of facial hair on all residents. Monitoring will occur 5 x weekly for 4 weeks. Then 3 times weekly for 4 weeks, then weekly for 4 weeks. 5. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. The QAPI committee includes the Administrator, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Social Worker, Dietary Manager, Infection Control Nurse, Activities Director, Housekeeping Manager, and Maintenance Director. Will be reviewed monthly for 100% compliance for 4 months. Date of Compliance 4/27/2023	

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F 677	Continued From page 5	F 677		

During a telephone interview on 03/29/23 at 6:11 PM with Nurse #6 she revealed she had worked with Resident #4 on 03/28/23 during the 7:00 AM - 3:00 PM shift. Nurse #6 said she did not notice the facial hair on Resident #4 but would have taken care of it if the resident had said something to her. Nurse #6 reported she did not ask the female residents about facial hair because it was a touchy subject, and they can be embarrassed by the question.

An interview conducted with Director of Nursing (DON) on 03/31/23 at 10:16 AM revealed NAs should be checking residents for facial hair during daily care and showers. Shaving was supposed to be offered during showers and were a part of activities of daily living (ADL) care. Refusals of grooming care needed to be documented. The DON stated she would like to see all residents asked about their facial hair and would like to see them shaved if that was what the resident desired.

2. Resident #24 was admitted to the facility on 01/11/22 with diagnoses that included stroke and hemiplegia.

Resident #24's care plan that was reviewed and revised on 01/11/23 revealed a focus for activities of daily living (ADL) self-care performance deficit due to general weakness. Interventions included assist of 1 person for personal hygiene.

Resident #24's quarterly Minimum Data Set (MDS) dated 01/12/23 revealed she had moderate cognitive impairment. Resident #24 required extensive assistance with personal hygiene. There were no episodes of behaviors or rejection/refusal of care.

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F 677	Continued From page 6	F 677		

An observation and interview with Resident #24 on 03/27/23 at 10:49 AM revealed she had facial hair to her upper lip and chin approximately an ½ inch long. Resident #24 stated she did not want the facial hair and if she could, she would want to have it shaved. Resident #24 reported she had been shaved by staff previously but was unable to recall the last time she had been asked by staff or assisted with shaving.

An observation and interview of Resident #24 on 03/28/23 at 9:33 AM revealed the facial hair on her chin had been shaved, but the facial hair remained on her upper lip. Resident #24 said she wanted the hair on her upper lip to be shaved as well. Resident #24 reported her chin had been shaved the previous day, but did not say anything about her upper lip to staff.

An interview was completed with NA #2 on 03/29/23 at 2:15 PM. NA #2 reported if a resident had facial hair and wanted to be shaved then she would assist them with shaving, even if it was not their scheduled bath day. NA #2 reported Resident #24 received a bed bath this that morning due to the resident not feeling well the previous evening. During the interview with NA #2 an observation was conducted of and Resident #24. NA #2 noted the facial hair to Resident #24's upper lip. Resident #24 informed NA #2 that she wanted to be shaved going forward due to not liking the facial hair.

An observation on 03/30/23 at 09:00 AM of Resident #24 revealed facial hair was still visible on her upper lip.

An interview with NA #6 was completed on

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F 677	Continued From page 7 03/30/23 at 10:25 AM and revealed she had cared for Resident #24 on the 7:00 AM - 3:00 PM shift on 03/28/23. NA #6 reported during ADL care she looked for facial hair on female residents and if the resident reported she wanted to be shaved, the NA would assist with shaving. NA #6 reported residents could be shaved even if it was not during their shower. During this interview with NA #6 an observation was conducted of Resident #24. NA #6 verified there was facial hair on Resident #24's upper lip. Resident #24 told NA #6 that she wanted the facial hair gone. NA #6 verbalized to Resident #24 that she would assist her with shaving. NA #6 reported that she usually cared for Resident #24 and could not recall Resident #24 ever refusing care and was unable to recall seeing the facial hair previously. During an interview with the Director of Nursing (DON) on 03/31/23 at 10:16 AM she revealed the NA's should be checking residents for facial hair during daily care and showers. Refusals of grooming care were to be documented. The DON stated she would like to see all residents asked about their facial hair and would like to see them shaved if that was what the resident desired.	F 677		
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.	F 695		4/27/23

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F 695	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, Nurse Practitioner and Hospice Nurse interviews, the facility failed to obtain orders for the use of oxygen for 2 of 3 residents reviewed for oxygen use (Resident #4 and Resident #54). The findings included: 1.Resident #4 was originally admitted to the facility on 10/19/22 and subsequently readmitted on 03/21/23 with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues), and history of pneumonia. Resident #4's quarterly Minimum Data Set (MDS) dated 02/27/23 revealed Resident was cognitively intact and used oxygen while at the facility. Resident #4's care plan last updated and reviewed on 03/27/23 showed Resident #4 had impaired gas exchange related to COPD and respiratory failure. The interventions included oxygen as ordered and vital signs as ordered. A review of Resident #4's electronic medical record revealed no physician orders for oxygen use or monitoring of oxygen saturation. Review of electronic medical administration record (eMAR)/treatment administration record (eTAR) showed no documentation about oxygen or monitoring of Resident's oxygen saturation between 02/18/23 and 3/28/23. Vital signs record from February to March 2023	F 695	F695 1. An order for oxygen was obtained on resident # 4 when she returned from the hospital on 4/3/2023. An order for oxygen was obtained on 3/30/2023 for resident # 54. 2. To identify other residents that have the potential to be affected, an audit of all residents with orders for oxygen was performed by the Unit Manager on 4/3/2023 to ensure orders were in place and accurate. No issues were identified. 3.To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on the expectation that any resident who requires oxygen must have a Physician order. The order must be entered into the electronic medical record by the licensed nurse. This education was completed on 4/11/2023. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. 4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor any new orders for	

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F 695	Continued From page 9 revealed no oxygen saturation documented since 2/17/23 (96% on oxygen via nasal cannula) Observation of Resident #4 on 03/27/23 at 10:00 AM revealed she was receiving oxygen via nasal cannula. Resident was visiting with Hospice Chaplain. Observation and interview with Resident #4 on 03/28/23 at 10:33 AM showed that she was receiving oxygen via nasal cannula at 3 liters per minute. Oxygen tubing was in place and portable oxygen tank was running continuously. Oxygen concentrator was observed in room. Resident #4 had a wet cough that she reported was somewhat productive. She said there was a chest x-ray scheduled for 03/28/23. Resident #4 reported she is supposed to receive oxygen at 3 liters per minute continuously due to having COPD and history of pneumonia. An interview with Nurse #1 on 03/30/23 at 2:06 PM revealed she had worked with Resident #4 on 3/26/23 on the day shift and resident received oxygen at 3 liters per minute on her shift. Nurse #1 could not recall if she had checked Resident #4's oxygen saturation but she stated that Resident #4 had her own pulse oximeter and she used it regularly to check her own oxygen saturation. Nurse #1 stated that there should have been an order in place for oxygen even when Resident #4 came back from the hospital. Nurse #1 stated there should have been an order to monitor Resident #4's oxygen saturation as well. Nurse #1 stated the Unit Manager, or the Director of Nursing usually entered orders in the EMR (electronic medical record) for new admits or re-admits.	F 695	oxygen in the clinical morning meeting for accuracy. Monitoring will occur 5 x weekly for 12 weeks. 5. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as is recommended by the committee. Will be reviewed monthly for 100%compliance for 4 months Compliance Date 4/27/2023	

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A phone interview with Nurse #2 on 03/29/23 at 6:11 PM revealed Resident #4 received oxygen for shortness of breath, and she had been using it for at least the past six months that she had taken care of her. Nurse #1 stated she was not sure why there was not a physician's order in place for Resident #4's oxygen. She further stated that Resident #4 was usually on her oxygen concentrator when she was in her room, and she rarely had to change the setting on her oxygen concentrator. On 3/28/23 during the day shift, the physical therapist notified her that Resident #4's oxygen saturation went down to 88-89% but when she checked Resident #4's oxygen saturation, it was around 91% on 3 liters per minute of oxygen.

An interview with the Unit Manager on 03/30/23 at 2:21 PM revealed Resident #4 should have an order for oxygen and an order to check her oxygen saturation at least every shift. The Unit Manager confirmed Resident #4 did not have an order in place for oxygen and monitoring of oxygen saturation. He stated that it had not been brought to his attention that Resident #4 did not have a physician's order for oxygen. He further stated the oxygen order must have been missed when Resident #4 came back to the facility from the hospital on 2/21/23 and her admission orders did not include an order for oxygen.

An interview with the Nurse Practitioner (NP) on 03/29/23 at 1:30 PM revealed Resident #4 was receiving oxygen because she was on hospice, and it was used for comfort due to her diagnosis of COPD. She was recently diagnosed with pneumonia and was currently being treated with antibiotics. The NP stated that Resident #4 should have an order for oxygen to be given to

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F 695	Continued From page 11	F 695		

keep her oxygen saturation greater than 90%. He also stated that the nurses should be monitoring and documenting her oxygen saturation.

During an interview with Director of Nursing (DON) on 03/31/23 at 10:16 AM she revealed residents receiving oxygen should have a physician's order in place for oxygen and an order for monitoring oxygen saturation. The DON stated Resident #4's oxygen order was missed because it wasn't included in her admission orders from the hospital when she returned to the facility after her most recent hospitalization.

2. Resident #54 was readmitted to the facility on 3/18/23. Review of the resident's cumulative diagnosis did not reveal a diagnosis which would indicate breathing impairment and/or the need for the use of supplemental oxygen.

A review of Resident #54's hospital discharge summary dated 3/18/23 revealed that Resident #54 was not receiving oxygen at the time of hospital discharge.

Resident #54's admission Minimum Data Set (MDS) dated 3/9/23 revealed that he was not cognitively intact. He was not coded for the use of oxygen.

Resident #54's care plan last updated 3/19/23 revealed Resident #54 was at risk for impaired gas exchange and ineffective airway clearance related to oxygen clearance. Care plan interventions did not include supplemental oxygen.

A review of the March 2023 physician orders

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revealed no order for supplemental oxygen use.

A review of the March Medication Administration Record (MAR) revealed documented oxygen saturation data taken while resident was receiving oxygen via nasal canula on 3/18/23, 3/19/23, 3/20/23, 3/22/23 and 3/27/23. Further review revealed no documentation on the MAR to administer the resident oxygen.

An observation made on 3/27/23 at 11:57 AM revealed Resident #54 with oxygen in his nares via nasal cannula at 2 liters per minute.

An additional observation was made on 3/27/23 at 12:26 PM when Resident #54 was receiving feeding assistance from a staff member in his room. Resident #54 was observed with oxygen in his nares via nasal cannula at 2 liters per minute.

An interview was conducted with the Nurse Practitioner (NP) on 3/29/23 at 1:30 PM. The NP stated that he thought that Resident #54 was receiving supplemental oxygen due to diagnosis of obesity and hypoventilation. The NP added that he thought the resident was on supplemental oxygen when he returned from the hospital on 3/18/23.

An interview with Nurse #2 on was completed on 3/29/23 at 2:07 PM. Nurse #2 stated Resident #54 wore supplemental oxygen at times. Nurse #2 explained that she knew which residents should be receiving oxygen by looking at the MAR.

A follow-up interview and record review were completed with Nurse #2 on 03/30/23 at 10:34 AM. Nurse #2 reviewed Resident #54's March

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F 695	Continued From page 13 MAR and stated she did not see an order for supplemental oxygen. Nurse #2 stated that she did not know why Resident #54 would be placed on oxygen. During an interview with Director of Nursing (DON) on 3/31/23 at 10:16 AM she revealed residents receiving oxygen should have a physician's order in place for oxygen and an order for monitoring oxygen saturation. An interview with the Administrator was conducted on 3/31/23 at 11:48 AM. The Administrator stated that there should have been an oxygen order in place.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		4/27/23

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F 732	Continued From page 14 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, review of the daily nursing staff postings, and staff interviews the facility failed to include the resident census information on the daily nursing staff posting for 7 of 9 days reviewed. The findings included: On 3/27/23 at 12:33 PM an observation was made of the facility's daily nurse staffing which was posted on the wall in the hallway across from the nurse's station. There was no census number listed on the nurse staffing sheet. A follow up observation was made on 3/27/23 at 2:59 PM. The census data had not been added. On 3/28/23 at 8:32 AM an observation of the posted nurse staffing sheet revealed no census data.	F 732	F 732 1. No residents were identified. The census was added to the daily nurse staff posting for the following dates: 3/23/2023 through 3/26/2023 and 3/27/2023 through 3/29/2023. 2.No residents were identified with this issue. 3. To prevent this from recurring, the Director of Nursing reeducated the unit Manager and the Staffing Coordinator on the expectation that the daily nurse staff posting must include the census. This education was completed on 4/11/2023. 4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor the daily nurse staff	

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F 732	Continued From page 15 On 3/29/23 at 8:44 AM an observation of the posted nurse staffing sheet revealed no census data. A follow-up observation on 3/29/23 at 11:10 AM revealed that the posted nurse staffing sheet had not been updated to include the resident census. The daily posted nurse staffing sheets were reviewed for 3/23/23 through 3/26/23. The filed daily posted nurse staffing sheets did not include the facility census data. On 3/31/23 at 9:43 AM a phone interview with Nurse #5 was completed. She stated that she worked 11:00 PM through 7:00 AM shift often and worked that shift on 3/28/23. She explained she did not include the resident census when filling out the posted nurse staffing sheet. On 03/31/23 at 12:10 PM a phone interview was completed with Nurse #4. Nurse #4 confirmed she worked the 11:00 PM - 7:00 AM shift and when she filled out the nursing staff posting she did not include the resident census. On 03/31/23 at 11:07 AM an interview was completed with the Director of Nursing (DON). The DON stated that 11:00 PM through 7:00 AM nurse was responsible for filing out the census data on the staffing sheet. An interview was conducted with the Administrator on 03/31/23 at 11:28 AM. He confirmed that the 11:00 PM through 7:00 AM nurse was responsible for posting the census data on posted nurse staffing sheets. He added that the census data should have been updated with any changes in census information	F 732	posting to ensure it is complete with the daily census. Monitoring will occur daily for 12 weeks. 5. The Director of Nursing will report the results of the monitoring to the QAPI committee for QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months. Date of Compliance 4/27/2023	

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F 732	Continued From page 16 throughout the shifts.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard an expired medication available for use in 1 of 2 medication carts (200 hall medication cart). The findings included:	F 761	F761 1. No residents were identified. The expired medication was removed from the 200 hall medication cart on 3/30/2023by the Unit Manager.	4/27/23

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F 761	Continued From page 17 An observation on 3/30/2023 at 1:47 PM of the 200 hall medication cart with the Unit Manager revealed a large opened bottle of Sodium Bicarbonate (antacid used to relieve heartburn and acid ingestion) which was marked with an expiration date of 1/2023. The bottle contained white round tablets and it was approximately ¼ full. An interview with the Unit Manager on 3/30/2023 at 2:00 PM revealed that the night shift nurse was responsible for checking the medication carts weekly. The Unit Manager stated that he checked the medication carts whenever there were changes in the medication orders or when a medication was discontinued and needed to be returned to the pharmacy. The Unit Manager also stated he last looked at the 200 hall medication cart a couple of weeks ago. Nurse #1, during a telephone interview on 3/30/2023 at 2:18 PM, indicated that she did not remember giving any Sodium Bicarbonate tablet during the day shift on 3/30/2023. She did not notice the bottle of expired Sodium Bicarbonate on the 200 hall medication cart. An interview with the Director of Nursing on 3/30/2023 at 2:30 PM revealed that the Unit Manager was supposed to check the medication carts weekly for expired medications.	F 761	2. No residents were affected. An audit of the 100 hall and 200 hall medication carts was performed on 3/30/2023 by the Unit Manager. No expired medications were found. 3. To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on the expectation that any medications that are out of date or expired must be removed and discarded per facility policy. This education was done on 4/11/2023. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/designee. 4. To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor the 100/200 hall medication carts to ensure no out of date or expired medications are present. Monitoring will occur 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks, then weekly for 4 weeks. 5.The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Will be reviewed monthly for 100% compliance for 4 months. Compliance Date 4/27/2023	

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F 806	Continued From page 18	F 806		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations and family, Registered Dietician (RD), and staff interviews, and record review, the facility failed to honor food preferences for 1 of 1 sampled resident reviewed for preferences (Resident #41). Resident #41 was admitted to the facility on 10/12/21 with the diagnoses of stroke and dementia. Resident #41's quarterly Minimum Data Set (MDS) dated 02/24/23 revealed Resident #41 had impaired decision making and needed supervision with eating. Review of the RD note dated 03/08/22 showed a physician order for a No added salt with regular texture foods, and fortified foods. No meat, only tuna and baked fish per Resident #41. An observation of the lunch menu for 03/27/23 revealed the following: Honey mustard pork roast Wild rice pilaf	F 806	F 806 1. Resident # 41 suffered no harm as a result of being served pork on her food tray. Resident was provided an alternate on 3/30/2023. Food Preference for resident #41 were updated on 3/30/23 and the meal tickets were updated as well. Meal Trays will be monitored by the dietary manager/designee to ensure resident #41 receives meals according to her preferences. 2. To identify other residents that have the potential to be affected, a 100% audit of all resident meal tickets will be conducted to ensure the Crandall Meal Tray ticket system is aligned with resident food preferences to ensure accuracy on 4/24/2023. 3. To prevent this from recurring, the Dietary Manager will reeducate all dietary staff and direct line staff on the	4/27/23

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F 806	Continued From page 19 Buttered spinach Bread or roll with margarine During the lunch dining room observation on 03/27/23 at 12:10 PM, Resident #41 was observed sitting at the table and not eating. Review of Resident #41's meal ticket revealed a no added salt, regular texture diet with dislikes of pork roast, pork loin, and chicken listed. Resident #41's lunch meal tray consisted of spinach, rice, and pork roast. The observation further revealed the Rehab Manager asking Resident #41 if she wanted something else. The Rehab Manager went to the kitchen and returned with a peanut butter and jelly sandwich. Resident #41 did not eat the sandwich and stated she did not want it. An observation of the lunch menu for 03/28/23 revealed oven fried chicken as the meat for the day. An observation of Resident #41's lunch tray on 03/28/23 at 12:30 PM revealed Resident #41 received mashed potatoes and gravy, mixed vegetables, and a meat patty with gravy. Resident #41's meal was set up in her room and she was observed looking at the food and not eating. Resident #41 was not able to report what type of meat the meat patty was. An observation of the lunch meal on 03/29/23 at 01:09 PM for Resident #41 revealed she had a tray with meatballs and noodles. Resident #41 was observed looking at her food and not eating the meal, however she was observed eating the desert. During an interview via telephone with Resident #41's responsible party (RP) on 03/28/23 at 11:12	F 806	expectation that meal tickets need to be checked for accuracy on the tray line to ensure resident preferences are honored and for the staff passing the trays to check preferences prior to serving the tray to the resident to ensure preferences are honored. This education will be completed on 4/26/2023. 4. To monitor and maintain ongoing compliance, the Dietary Manager/designee will monitor all meal trays for accuracy and ensure resident preferences are honored. Monitoring will occur 5 times a week for 12 weeks. 5. The Dietary Manager will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. The QAPI committee includes the Administrator, Director of Nursing, Medical Director, Pharmacist, Business Office Manager, Social Worker, Dietary Manager, Infection Control Nurse, Activities Director, Housekeeping Manager, and Maintenance Director. Will be reviewed monthly for 100% compliance for 4 months. Date of Compliance 4/27/2023	

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AM, the RP revealed Resident #41 was a vegetarian when she admitted to the facility. The RP continued to explain Resident #41 was not a big meat eater but did sometimes prefer fish.

An interview was completed on 03/29/23 at 04:07 PM with Rehab Manager regarding the lunch observation on 03/27/23. The Rehab Manager stated Resident #41 told her that she did not like the meal she had so she offered Resident #41 a peanut butter and jelly sandwich because she thought it would be more appealing to Resident #41.

An interview was completed on 03/30/23 at 03:08 PM with the Dietary Manager. She revealed she would speak to residents upon admission and weekly about food preferences. The Dietary Manager reported Resident #41 could say what she wanted to eat and ate only baked fish and tuna when she admitted to the facility. The Dietary Manager reported she would speak with Resident #41 and her RP to update food preferences and if needed she could accommodate a diet with more vegetables.

An interview was completed via telephone with the Registered Dietician (RD) on 03/30/23 at 04:15 PM. The RD revealed Resident #41's preferences were fish and tuna, and she did not like other meats. The RD further explained Resident #41 mainly ate vegetables and fish. The RD voiced Resident #41 should not have been served pork or chicken if her preferences were fish and tuna.

During an interview with the Administrator on 03/31/23 at 10:35 AM he stated residents should be asked about their preferences and the meal

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F 806	Continued From page 21 tickets match with orders and preferences.	F 806		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such 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	F 867		4/27/23

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity 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

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F 867	Continued From page 23 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment	F 867	F 867 QAPI F 695 Respiratory/Tracheostomy Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 24 and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put into place following the 2/11/22 annual recertification surveys. This was for F695-Respiratory/Tracheostomy Care and Suctioning. This deficiency was cited again on the annual recertification survey 3/31/23. This continued failure of the facility during two consecutive recertification surveys shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F695- Respiratory/Tracheostomy Care and Suctioning: Based on observations, record reviews, resident, staff, Nurse Practitioner and Hospice Nurse interviews, the facility failed to obtain orders for the use of oxygen for 2 of 3 residents reviewed for oxygen use (Resident #4 and Resident #54). During the recertification survey conducted on 2/11/22 the facility failed to obtain orders for the use of supplemental oxygen for 1 of 3 residents reviewed for oxygen use. During an interview on 3/31/23 at 1:19 PM the Administrator explained a breakdown in the system occurred due to human error. The Administrator continued to explain human error caused the lack of physician order for oxygen use. He stated the facility had implemented standing orders for oxygen use with oxygen saturation monitoring.	F 867	and Suctioning 1. Resident # 4 and resident # 54 suffered no harm as a result of orders for oxygen not being obtained. An order for oxygen was obtained on resident # 4 when she returned from the hospital on 4/3/2023. An order for oxygen was obtained on 3/30/2023 for resident # 54. 2. To identify other residents that have the potential to be affected, an audit of all residents with orders for oxygen was performed by the Unit Manager on 4/3/2023 to ensure orders were in place and accurate. A visual audit of all residents will be conducted by Director of Nursing or designee to ensure all residents who are receiving oxygen have appropriate orders by 4/26/2023. 3. To prevent this from recurring, the Director of Nursing/designee reeducated all licensed nurses on the expectation that any resident who requires oxygen must have a Physician order. The order must be entered into the electronic medical record by the licensed nurse. This education was completed on 4/11/2023. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. On 4/18/2023 the Regional Clinical Director provided reeducation to the Administrator and the Director of Nursing on F tag 867. 4. To monitor and maintain ongoing compliance, the Director of Nursing or	

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F 867	Continued From page 25	F 867	designee will monitor any new orders for oxygen in the clinical morning meeting for accuracy. Monitoring will occur 5 x weekly for 12 months. 5. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. Regional Clinical Director will review audit findings monthly and recommendations in conjunction with the QA committee. Will be reviewed monthly for 100% compliance for 4 months. Date of compliance 4/27/2023	