STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345294	A. BUILDING _____ B. WING _____	C 07/27/2023

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AUTUMN CARE OF SHALLOTTE	237 MULBERRY STREET SHALLOTTE, NC 28459

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 07/23/23 through 07/27/23. The facility was found to be in compliance with the requirment CFR 483.73 Emergency Preparedness. Event ID #T3LE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/23/23 through 07/27/23. Event ID # T3LE11. The following intakes were investigated: NC00201288 and NC00205137 2 of the 2 allegations resulted in deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		8/21/23

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

Electronically Signed | 08/15/2023

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F 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the privacy of residents' records when the computer screen was left open with resident information exposed during two observations for 1 out of 4 medication carts observed. Findings included: a. A continuous observation of a medication cart on the 400 Hall at 11:45 AM until 12:05 PM on 07/24/23 revealed the computer screen was left open and displayed patient information for 15 minutes until it defaulted to a secured screen. Nurse #9 was not in view of the medication cart. A therapist and a resident in a wheelchair were noted to be adjacent (approximately 2 feet away) to the medication cart for 20 minutes, a family member with a resident in the wheelchair walked by the cart twice, two aides walked by the cart, and a resident in a wheelchair was parked in front to of the cart for 10 minutes while waiting for the nurse.	F 583	F583 On July 26, 2023 nurse #9 locked her computer screen to protect the personal health information of the residents and was educated by the Director of Nursing on maintaining the privacy of residents records. On July 27, 2023 the Director of Nursing did a facility inspection to verify that all computer screens were locked or turned as to not display personal health information. No additional issues were identified during the inspection. The Director of Nursing or designee will education all clinical staff on maintaining the privacy of residents records by 8/16/2023. The Director of Nursing or designee will do a facility inspection 5x week for 12 weeks to ensure the privacy of residents	

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F 583	Continued From page 2 An interview with Nurse #9 on 07/24/23 at 12:05 PM revealed she got pulled away and distracted and added she "messed up." Nurse #9 stated she knew she was supposed secure resident information before walking away from her computer to keep staff and other residents from viewing other resident's private information. b. A continuous observation of the 400 hall medication cart on 07/26/23 at 3:20 PM revealed Nurse #9 had left the computer screen open revealing resident information. Staff and residents were observed passing by the cart while it remained open. The resident information was displayed for approximately 5 minutes while Nurse #9 was observed at the other end of the hall. An interview with Nurse #9 on 07/26/23 at 3:25 PM upon return to medication cart revealed she did not know why she kept leaving the screen opened and added "I'm not very good at this today." An interview with the DON on 07/27/23 at 1:50 PM revealed the nursing staff were educated regarding securing resident information anytime they walked away from their computer/medication cart. He stated exposing resident information was a Health Insurance Portability and Accountability Act (HIPPA) violation.	F 583	records is being maintained. If there are any issues during the inspection the resident records will be immediately put away or covered and the staff member responsible will receive re-education. The audit will be reviewed by the Quality Assurance Performance Improvement committee monthly for three months. The committee may alter the plan of correction or extend the audits to ensure ongoing compliance. Audits will begin 8/17/2023.	
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, neglect, misappropriation of resident property,	F 600		8/21/23

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F 600	Continued From page 3 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 observations, record review, staff, Psychiatrist, Nurse Practitioner interviews and the Medical Directors interview the facility failed to protect a residents right to be free from abuse when a cognitively impaired resident (Resident # 46) had physical and verbal altercations against another cognitively impaired resident (Resident #53). During an initial altercation Resident #46 was observed grabbing Resident #53's arms and pulling them away from his face and yelling at him, there were no injuries reported. During a second altercation Resident #46 became agitated and attempted to lash out at Resident #53, there were no injuries reported. During the most recent altercation Resident #46 verbally and physically lashed out at Resident #53 by yelling at him and grabbing his left arm which resulted in large bruise on his left wrist and thumb region as documented by Nurse Practitioner #2. Due to the altercations initiated by Resident #46 toward Resident #53, a reasonable person would have experienced intimidation and fear. This was for 1 of 2 residents reviewed for abuse. Findings included.	F 600	F600 Resident #46 was moved to another room away from resident #53. Both residents were assessed by a nurse on 7/24/2023. Both residents were placed on increased visual monitoring for safety and to identify any escalating behaviors. Both residents were assessed by the psych providers on 7/26/2023. The Director of nursing or designee will interview all alert and oriented residents by 8/14/2023 as it relates to abuse, mistreatment, types of abuse and abuse reporting. The Director of nursing or designee will assess the skin of each non interviewable resident by 8/14/2023 to ensure there are no areas of unknown origin that could potentially be a result of abuse. The Director of Nursing or designee will educate all staff on Abuse/Neglect and Dementia: Dealing with Difficult Behaviors by 8/16/2023.	

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F 600	Continued From page 4 Resident #46 was admitted to the facility 06/20/20 with diagnosis including dementia with behavioral disturbance, delusional disorder, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 06/09/23 revealed Resident #46 had severely impaired cognition with inattention and disorganized thinking. He required limited one person assistance with bed mobility, transfers, and activities of daily living (ADL). Resident #46 had no impaired range of motion and self-propelled a wheelchair for mobility. Resident #53 was admitted to the facility on 04/20/23 with diagnoses including Alzheimer's disease, and dementia without behaviors. The quarterly Minimum Data Set (MDS) assessment dated 05/05/23 revealed Resident #53 had severely impaired cognition with no behaviors. He required limited one person assistance with bed mobility, transfers, and activities of daily living (ADL). Resident #46 had no impaired range of motion and self-propelled a wheelchair for mobility. A care plan dated 05/05/23 revealed Resident #53 had impaired cognitive function and impaired thought processes related to Alzheimer's. Resident had severe cognitive impairment, inattention, difficulty focusing, and disorganized thinking. The goal of care included Resident #53 would be able to communicate basic needs daily. Interventions included; to administer medications as ordered, document and report changes in cognitive function to the physician, cue, reorient and supervise the resident as needed.	F 600	The Director of Nursing or designee will review and audit the 24 hour report 5x week for 12 weeks to ensure all escalating behaviors are being handled appropriately and the facility is ensuring interventions are being implement to prevent resident to resident abuse. The behavior audits will be reviewed in resident review weekly and monthly in the QAPI meeting for three months. The QA team may alter the plan of correction or extend the audits to ensure ongoing compliance. Audits will begin 8/17/2023.	

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A progress note dated 06/13/23 at 4:37 PM documented by Nurse #6 revealed Nurse Aide (NA) #6 witnessed Resident #46 wheel himself to Resident #53 in the hallway and attempt to swing at the resident. There were no injuries noted. Resident #46 stated he was all over the place, and on the wrong hall. The nurse explained to Resident #46 that Resident #53 lived there. The nurse separated the residents, both residents were confused. Nurse Practitioner #1 was made aware."

During a phone interview on 07/27/23 at 3:34 PM Nurse #6 stated regarding the altercation between Resident #46 and Resident #53 on 06/13/23 she did not recall the nurse aide (NA#6) reporting physical contact, only a verbal altercation. She stated as far as she was aware there were no injuries or bruising following the altercation on 06/13/23. She stated the residents were redirected and kept separated following the incident. She stated the incident on 06/13/23 was reported to her unit manager.

During a phone interview on 07/27/23 at 2:25 PM Nurse Aide #6 stated she witnessed the altercation between the two residents on 06/13/23. She stated she was walking down the hall and heard Resident #46 get loud and he was in the hallway in Resident #53's personal space. She walked up to them and asked Resident #46 what was wrong, and he stated, "get this man out of here". She reported Resident #46 had this behavior before, so she tried to redirect him and then Resident #46 started "coming at her" with aggression. She stated she removed him from the situation quickly, as he was grabbing Resident #53's arm, and grabbing at his head. She stated Resident #53 "put his arms over his

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head as in a fetal position" and Resident #46 started pulling Resident #53's arms off of his head and made physical contact. She stated she did not recall any injury from the incident. She stated she was not their assigned nurse aide that day she just happened to be walking through the unit when it happened. She stated she had witnessed verbal behaviors between the two residents in the past. Resident #46 would go right behind Resident #53 and say things like, "get this guy out of here" and yell at him. She stated Resident #53 seemed to be in his own world and would not pay him any attention.

During an interview on 07/27/23 at 3:44 PM Unit Manager #1 stated she was made aware of the altercation on 06/13/23. She stated she thought Nurse Aide #6 said they were fighting but then she talked to Resident #53, and he stated, "he felt like the guy was chasing him and he was all over the place". Resident #53 stated to her, " I just try to mind my own business and he keeps following me". She stated Resident #46 tried to be the hall monitor and had no recollection of any incidents or altercations. She stated Nurse #6 informed her that Resident #46 had tried to grab Resident #53's arm but did not recall her saying he had made any physical contact. She stated Resident #46 had been at the facility for a long time and although he had dementia, he knew his roommate and knew the female residents. She indicated Resident #46 had no verbal or physical aggression displayed toward other residents. She stated although Resident #53 had dementia he was aware of how Resident #46 was and if he saw Resident #46, he would go the other way.

A care plan revised on 06/18/23 revealed Resident #46 had altered cognition with diagnosis

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of advanced dementia/Alzheimer's and remained on medication for mood stabilization, was currently on a cognitive enhancer for cognitive loss, and had a history of verbal confrontations with staff and residents, an attempted episode of becoming physical with another resident, and scored 0 on the most recent BIMS (Brief Interview for Mental Status- a tool used to screen and identify the cognitive condition of residents.), which had improved with no reported aggression or behavioral concerns at this time. The goal of care included Resident #46 would be comfortable and familiar with surroundings without complications. Interventions included: to anticipate needs and observe for nonverbal cues and explain events and procedures prior to starting. Introduce self, and orient to person, place, and time.

A Psychiatric evaluation note dated 06/21/23 revealed in part; "Resident #46 was seen today for follow up on his dementia and at the request of staff for anxiety related to sundowning. Nursing staff told provider that he had episodes of being moody and irritable, particularly in the evening. Nurse also gave report of an incident last week where he became verbally aggressive with another resident (Resident #53) and also attempted to physically attack him but could not because he was in a wheelchair. Nurse told provider that he still cares for himself but there were days that he became very agitated, and it was difficult for them to deescalate him. Nurses stated that it did not occur every evening. Upon speaking with Resident (#46), he told this provider that he was doing good and gets along with everybody. Orders were written to start Ativan (antianxiety medication) in the evening as needed for anxiety or agitation for 14 days."

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Record review revealed a physicians order dated 06/21/23 for Resident #46 to start Ativan 0.5 milligrams (mgs) as needed for agitation for 14 days. This order was updated on 07/19/23 to give Ativan 0.5 mgs as needed for agitation for 14 days.

Review of Resident #46's Medication Administration Record (MAR) dated June 2023 revealed he did receive Ativan as needed for agitation.

Review of Resident #46's Medication Administration Record (MAR) dated July 2023 revealed he did receive Ativan as needed for agitation.

A progress note dated 07/07/23 at 9:44 PM documented by Nurse #7 revealed Resident #46 was noted to become agitated this evening and attempted to thrash out at male resident (#53) on the unit. Nurse #7 intervened and asked Resident #46 to return to his room. Resident #46 was compliant and sat in front of his room doorway and remained compliant the remainder of the shift until he went to bed.

Attempts were made to contact Nurse #7 during the investigation with no response. No other staff interviewed could provide details of the altercation on 07/07/23.

A progress note dated 07/24/23 at 3:34 PM documented by Nurse #6 revealed Resident #53 was in the hallway minding his own business and was approached by Resident #46. Then Resident #46 yelled at Resident #53 and grabbed Resident #53 by the arm. Nurse #6 separated the residents

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immediately. There were no injuries noted. Resident #53 stated Resident #46 was always starting with him. Nurse Practitioner #2 was notified. The family was notified as well.

A weekly skin evaluation note dated 07/25/23 at 4:56 PM for Resident #53 and documented by Nurse #6 revealed, a newly identified skin issue of "bruise to back of left hand from resident altercation.". There was no further description of the evaluation.

During a follow up interview conducted on 07/25/23 at 5:00 PM Nurse #6 stated Resident #46 and Resident #53 both had dementia. She stated Resident #46 had been in the facility for a few years, was oriented to person only and had periods of sundowning. She stated he had occasions where he would yell at the male residents on his hall but had never been physically aggressive toward the other residents. She stated Resident #46 thought he was the "protector" of the female residents on the hall. She stated Resident #53 was just admitted in April 2023 and was oriented to person only and did not have aggressive behaviors toward other residents. She stated Resident #46 and Resident #53 had verbal altercations between each other approximately 2-3 times a week but as far as she was aware there had been no physical contact until the altercation on 07/24/23. She stated Resident #46 was the aggressor not Resident #53. She stated there was something about Resident #53 that triggered Resident #46 and he would become verbally aggressive toward him. She stated both residents resided on the same hall just a few doors down and across the hall from each other in semi-private rooms. She stated Resident #46 had to pass by Resident

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#53's room to get to other areas of the facility including the nurses' station, dining room or activities. She stated Resident #46 was not aggressive toward his roommate and acted as his roommate's protector. She stated there had been no issues between Resident #53 and his roommate. She indicated interventions included redirection and to keep the two residents separated, but indicated they were both able to self-propel in their wheelchairs and both roamed around the facility during the day. She stated the altercation on 07/24/23 occurred as Resident #46 was coming down the hallway in his wheelchair to go to activities and Resident #53 was just sitting in the hallway in his wheelchair outside of his room. Resident #46 started yelling at him and then grabbed Resident #53's arm and she intervened and separated the two residents. She stated Resident #53 stated to her that Resident #46 was always starting something with him. She stated the Nurse Practitioner was made aware of the behaviors and both residents were followed by the Psychiatrist. She stated both residents received medications for mood and behaviors. She stated Resident #46 received Ativan as needed and had not been agitated prior to the altercation and had not received the Ativan that day. She stated she did administer Ativan 0.5 milligrams following the altercation. She indicated Resident #46 remained calm with no aggressive behaviors toward Resident #53 the remainder of her shift. She stated she reported the physical altercation on 07/24/23 to the unit manager, who reported it to the Director of Nursing.

During an interview on 07/26/23 at 3:45 PM the Social Worker stated she was aware of the physical altercation on 07/24/23 between Resident #46 and Resident #53. She indicated

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this was the first reported incident regarding physical contact with injury between the two residents. She stated she spoke with both residents on 07/25/23 the day flowing the altercation. She stated Resident #46 was happy and did not remember the incident with Resident #53 the day prior. She stated she spoke with Resident #53 also and stated Resident #53 did not remember the incident either. She stated she would continue to follow up with both residents.

A progress note dated 07/25/23 documented by Nurse Practitioner #2 regarding Resident #53 revealed in part; " he was seen at the request of staff post resident to resident altercation on 07/24/23. Nursing reported the incident to the on-call provider and denied any injuries directly after the incident. However, today staff noticed that Resident #53 had a large bruise on his left wrist and thumb region, with skin intact. Resident #53 denied pain or limited range of motion of the left wrist. Per the staff Resident #53 was minding his own business when another resident approached him yelling and grabbed the resident by the left arm. Staff separated the residents immediately, residents family was notified, no further intervention was required. The physical exam noted in part; Resident #53 was a frail, elderly male, who was alert and oriented to person only. Left wrist/hand bruise healing with skin intact. The plan of care revealed traumatic bruising of left wrist. No further assessment required, full range of motion, site healing, no pain, no new orders."

During an interview on 07/25/23 at 5:30 PM Resident #53 was sitting in his wheelchair in the hallway. He was alert, oriented to self, he was calm, and in no distress. He was observed with a

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large, bruised area on his left hand and thumb with skin intact. Resident #53 stated, "I was just sitting there, and he grabbed my arm and held on to it". Nurse #6 approached as Resident #53 described what happened during the altercation on 07/24/23. Resident #53 continued to say, "I wasn't doing anything, he grabbed my arm and wouldn't let go". Nurse #6 then stated Resident #53 described the altercation exactly how it happened. Resident #53 was asked by the surveyor if he was fearful of that resident he stated "No". When asked if he wanted to move his room to another hall he stated, "No". Resident #53 continued to talk and when asked if he knew where he was, what year it was, or who is nurse was he stated "No".

During an observation of Resident #46 on 07/25/23 at 5:45 PM he was observed sitting in his wheelchair in his room. He was calm, smiling and was coloring a picture. He was oriented to self only. He could not answer questions meaningfully.

A Psychiatric evaluation note for Resident #53 dated 07/26/23 revealed in part; "Resident was seen today at the request of the facility for physical confrontation with another resident. The social worker told this provider that Resident #53 was not the resident who initiated the interaction but was the one who was physically assaulted. Nurse told this provider that other than the negative incidents with the same resident he remained at baseline. Upon speaking with him this provider noted that the resident that assaulted Resident #53 was seen coming towards him. Resident #53 told this provider that he himself was a nice guy and was friendly with everybody. He told this provider that he was

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sitting minding his own business when the resident came up to him and grabbed his arm. He stated that he held it for "5 minutes" . He told this provider that he just wanted to "get along with everybody since I am here". He stated he would rather be at home but if he was going to be here, he wanted it to be pleasant. He stated he did not want to have problems with anybody. Nursing staff told this provider that he was not the aggressor in these confrontations with the other resident and otherwise did well, with no reported behavioral issues. This provider did note that he had a large contusion on his left hand. The plan of care included to continue current medications and monitor for mood or behavior changes."

A Psychiatric evaluation note for Resident #46 dated 07/26/23 revealed in part; "Resident was seen today after he physically assaulted a resident and to follow up on his dementia. Provider was told the incident occurred on Monday 07/24/23 where Resident #46 was the aggressor with another resident, grabbing the resident by the wrist and leaving bruises on his arm. Nurse told this provider that Resident #46 did not recall the incident when she asked him about it. Upon speaking with him resident (#46) went off on some delusional tangents. This provider noted he appeared to be very confused and did not recall hitting anyone. Nursing staff reported there were times when he gets agitated, but it was usually when he saw this particular resident at which time, he will immediately go to him and engage in confrontations. Nurse told this provider that Resident #46 is the aggressor in each of the confrontations. This provider does note that while sitting and speaking with the nurse at the nursing station, this provider witnessed Resident #46 approaching the resident in which

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he has had said confrontations. He quickly approached the resident and appeared angry and agitated. The nurse aide redirected him down the hall away from the resident."

During an interview on 07/26/23 at 4:08 PM the Psychiatrist stated she was made aware of the altercation between Resident #46 and Resident #53 through email on 07/24/23 the day of the occurrence. She stated Resident #53 was not the aggressor. She stated Resident #46 was very confused when she talked to him, and his speech was word salad, and it was hard to piece together his story. She stated Resident #46 did not remember hurting anybody and then he stated he went out with his family last night on the wagon. She stated Resident #46 denied knowing anything regarding the allegation. She stated she informed staff today to keep the two residents separated. She stated Resident #53 was friendly with cognitive impairment but not impaired to the extent of Resident #46. She stated Resident #53 was content. She reported the medications were adjusted for Resident #46 for agitation related to his dementia. She increased his Depakote (an anticonvulsant prescribed in treatment of mood and behavior disturbance) to 250 milligrams (mgs) twice a day. She stated she was aware of the previous altercation regarding an incident in June 2023 when Resident #46 made an attempt to physically attack Resident #53 but per nursing staff during that incident no physical contact was made and there was no injury. She stated she prescribed an as needed dose of an antianxiety medication following that incident. She stated she was not aware of any injury until this most recent altercation on 07/24/23. Resident #53 stated to her that he was not fearful and would try to stay away from Resident #46. She stated Resident

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#53 received an antipsychotic medication nightly and was stable on the medication. She stated she spoke to nursing staff today and the Administrator on the importance of separating these residents on different halls due to safety concerns.

During an interview on 07/26/23 at 10:00 AM Nurse Aide #7 stated she did not typically work the hall that Resident #46 and Resident #53 resided on. She stated she did not witness the incident between the residents on 07/24/23 but stated she had witnessed verbal altercations between the two residents in the past maybe a couple of times per month. She stated Resident #46 was the "protector" of the hall and would become verbally aggressive toward Resident #53. She added there was something about Resident #53 that triggered Resident #46 but did not know why. She stated both residents could self-propel their wheelchairs and would pass each other on the hall. She stated interventions included; redirection, activities and keeping the residents separated. She indicated she had received education on dementia care and abuse training.

During an interview on 07/26/23 at 5:00 PM Nurse Aide #4 indicated Resident #46 and Resident #53 both had dementia. She stated she typically worked their hall during the evening shift and was routinely assigned to provide their care. She indicated there had been verbal altercations between the two residents in the past but stated she had not witnessed physical altercations between them. She stated they just try to keep the residents separated. She stated she had received dementia care training and abuse training in the last few months. She reported no issues between the two residents today.

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During a phone interview on 07/27/23 at 2:10 PM Nurse #8 stated she routinely provided care to both residents. She stated when Resident #53 first came to the facility it seemed as though both residents were friends, and they would talk. She stated Resident #46 thought he was the "watcher" of the hall and had to take care of the female residents. She stated Resident #46 thought his roommate was a child and he had to take care of him. She stated he was started on Depakote and had medication adjustments a couple of times and since then she had not seen physical aggression between the two residents. She stated Resident #46 said things that made no sense. She stated they kept them separated and kept an eye on them. She stated she had never witnessed physical contact only verbal altercations. She stated Resident #53 was routinely up and down the hallway and around the facility in his wheelchair. She stated it was reported to her on one occasion when Resident #46 made a verbal threat in Resident #53's face saying to him he could get punched in the face but that was a couple of months ago. She indicated that had been reported to the unit manager who would then report to the Director of Nursing. She stated both residents were followed up with by the Psychiatrist. She stated Resident #46 thought he was the guard and said things such as "he has to watch the girls". She stated she had abuse and dementia care training this year, through an online platform and also handouts from in-services a couple of times a year. She stated she received monthly dementia training.

During an interview on 07/27/23 at 12:11 PM Nurse Practitioner #1 stated he was made aware

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that Resident #46 had altercations with residents before but there had been no reported serious injuries in the past. He stated both residents were followed by the Psychiatrist who managed their medications. He stated he typically did not make medication adjustments to the medications that were prescribed by the Psychiatrist unless it was an emergency situation. He stated both residents continued to be followed by the Psychiatrist.

During an interview on 07/27/23 at 1:32 PM the Medical Director indicated he was fairly new to the facility. He stated he was made aware of the behaviors regarding Resident #46 but was not aware of specific details of the allegations. He indicated both residents were seen by the Nurse Practitioner following the incident on 07/24/23 and both residents were followed by the Psychiatrist.

During an interview with the Director of Nursing on 07/27/23 at 4:13 PM he stated staff were aware that Resident #46 and Resident #53 needed to be separated as much as possible. He stated he was aware of verbal altercations between the two residents but there had been no reports of a physical altercation or injury until the incident on 07/24/23. He stated they were planning to move Resident #46 to another hall to keep them separated as much as possible but stated both residents were able to self-propel in their wheelchair and both moved around the facility during the day. He stated moving forward staff would need to be more diligent in keeping the two residents separated.

During an interview with the Administrator on 07/27/23 at 4:00 PM she stated she was aware of the verbal altercations between Resident #46 and Resident #53 but there had been no physical

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F 600	Continued From page 18 contact or injury reported to her until the altercation on 07/24/23. She stated both residents had dementia, and both were followed by the Psychiatrist and interventions had been implemented such as keeping the residents separated as much as possible. She stated that following the physical altercation that occurred on 07/24/23 she followed procedure and made the report to Adult Protective Services and to the State. She stated her investigation was ongoing at this time. She stated they were making arrangements to move Resident #46 to another hall due to the altercation on Monday in order to keep the residents separated as much as possible.	F 600		
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 interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of discharge status (Resident #93), type of entry (Resident #61), and nutritional status (Resident #38), for 3 of 20 residents whose MDS assessments were reviewed. Findings included: 1. Resident #93 was admitted to the facility on 04/25/23 and discharged to home on 05/10/23. Diagnoses included, in part: Dementia, anemia, and muscle weakness.	F 641	F641 The MDS coordinator modified the Section A of the MDS, dated 5/10/2023, for resident #93. The MDS coordinator modified the Section A of the MDS, dated 1/24/2023, for resident #61. The MDS coordinator modified the MDS, section K, for resident #38. The MDS coordinator will review all MDS submitted after 7/15/2023 to ensure accuracy of Section A and Section K by 8/16/2023.	8/21/23

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F 641	Continued From page 19 Review of a Discharge/Return not anticipated MDS assessment dated 05/10/23 documented Resident #93 was discharged to an acute hospital. Review of a Social Services progress note written on 05/01/23 at 12:57 PM documented Resident #93 was short term rehabilitation and was to return home with her family and home health services upon completion of therapy. Review of the Discharge Instructions written on 05/05/23 documented the discharge destination for Resident #93 as home with family. Review of an additional Social Services progress note written on 05/08/23 at 1:42 PM documented Resident #93 was to be discharged home with her family and services for Home Health Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Nurse Aide services and Social Work services had been arranged through the home health agency. There were no equipment needs. A follow-up appointment was made with her primary care physician for May 15, 2023 at 11:30 AM. Review of a nursing progress note written by Nurse #1, dated 05/10/23 at 10:53 AM, documented the following: Resident discharged via private vehicle with family this shift. Medications reviewed and all medications available at home. No complaints noted. In an interview with Nurse #1 at 11:05 on 7/26/23 she stated after looking at the resident's picture that she vaguely remembered her but did not recall the actual discharge. She did know that she has never discharged a resident to the	F 641	The Regional Director of Clinical Services will educate the MDS coordinators and the dietary manager by 8/16/2023 on MDS assessment accuracy. The DON or designee will audit all discharge MDS section A, all readmission MDS section A and Section K for each submitted MDS 5x week for 12 weeks to ensure accuracy of the assessments. Any errors identified will be modified and re-education will be provided. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for three months. The plan of correction may be altered or the audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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hospital via a private family car and was 100% sure that she discharged the resident to home with her family after reading the discharge note she documented. She reiterated that if a resident was discharged to a hospital, the resident was always transported by EMS and never by a private vehicle.

In an interview with MDS Nurse #2 on 7/26/23 at 11:15 AM she stated she did not remember the resident. She reviewed the progress notes and stated she must have read something in the record that led her to assume the resident was discharged to an acute hospital and that was why she coded the assessment as discharged to an acute hospital. She concluded the assessment was coded in error and that the resident had been discharged to home.

In an interview with the Administrator on 07/27/23 at 11:00 when discharge information was shared with her, she agreed the assessment had been coded in error.

2. Resident #61 was originally admitted to the facility 12/22/22 with medical diagnoses which included in part: COVID pneumonia, Chronic Obstructive Pulmonary Disease, atrial fibrillation, and stroke.

Review of Resident #61's MDS assessments revealed assessments were completed with the following reference dates: an entry assessment on 12/22/22, and admission on 12/29/22, a discharge return anticipated on 1/19/23, an entry on 1/24/23, a quarterly on 1/26/2023, and a discharge return anticipated on 1/26/23.

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Review of Resident #61's 1/24/23 entry MDS assessment revealed resident was coded as a new entry into the facility.

Interview with the MDS Coordinator on 7/27/23 at 3:05 PM revealed she must have missed it when she incorrectly coded Resident #61 as a new entry into the facility on 1/24/23. The MDS Coordinator stated she was familiar with the MDS questions and the coding of entry and reentry in the assessments. The MDS Coordinator stated it was an error that Resident #61 was coded as an entry.

3. Resident #38 was admitted to the facility on 7/13/20 with diagnoses which included in part: hypertension, acute kidney failure, and dementia.

Review of Resident #38's medical record revealed a weight of 181 pounds was recorded on 3/3/23 and a weight of 177 pounds was recorded on 4/10/23.

Review of Resident #38's 4/12/23 quarterly MDS assessment indicated resident had severe cognitive impairment, a weight of 181 pounds with no weight loss and did not receive a mechanically altered diet. Review of the MDS data revealed that the nutritional status section of Resident #38's assessment was signed as complete by the Dietary Manager (DM) on 4/9/23.

Interview on 7/27/23 at 11:15 AM with the DM revealed that she completed the quarterly MDS assessments, and the registered dietician completed the annual and significant change assessments. The DM stated that she looked at the resident's weight and diet when she completed the MDS assessment. The DM stated

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F 641	Continued From page 22 the assessment reference date (ARD) was used on the MDS to identify the last day of the look back period and the assessment was to use a weight as close to the ARD but not after that date. The DM stated she did not know why she completed and signed the MDS on Resident #38 prior to the ARD and used the prior month's weight. Interview on 7/27/23 at 3:05 PM with the MDS Coordinator revealed that Resident #38's 4/12/23 quarterly MDS was coded in error. The MDS Coordinator further stated that the DM was not to complete assessments prior to the ARD and was to use the weight obtained closest to the ARD. Interview on 7/27/23 at 4:30 PM with the Director of Nursing (DON) revealed that he expected that the MDS assessments would be completed accurately. The DON indicated that education and auditing was needed to ensure that errors did not occur.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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, record review, and staff interviews, the facility failed to use 2-person assistance when transferring a resident using the	F 689	F689 Accidents Resident #22 was assessed on 7/30/2023	8/21/23

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F 689	Continued From page 23 mechanical lift and according to care planned interventions for 1 of 1 resident (Resident #99) reviewed for supervision to prevent accidents. Findings included. Resident #99 was admitted to the facility on 01/08/18 with diagnoses including cerebral vascular accident, and non-Alzheimer's dementia. A care plan dated 05/05/23 revealed in part; Resident #99 had expected decline related to advanced vascular dementia, end stage heart failure, advanced age, and continued cognitive decline. The goal of care included Resident #99's needs would be met daily. Interventions included in part; to transfer with the total mechanical lift using two-person assistance, resident was non-ambulatory. The Minimum Data Set (MDS) assessment dated 05/15/23 revealed Resident #99 had severely impaired cognition and required total dependence with bed mobility, transfers, and activities of daily living. She had impaired range of motion of bilateral upper and lower extremities. There were no falls since admission, and no wounds or skin tears. Review of the Treatment Administration Record dated July 2023 revealed Resident #99 required transfers with the total mechanical lift using 2-person assistance. The resident's care guide which is utilized as a reference to determine care needs was posted on Resident 99's closet door in her room. The care guide revealed to transfer using the mechanical lift with 2-person assistance.	F 689	with no visible signs of injury related to the improper transfer. The DON or designee will interview all alert and oriented residents as it relates to transfer safety by 8/16/2023. The DON or designee will assess all cognitively impaired residents by 8/16/2023 to ensure there are no injuries that could potentially be from an improper transfer. The Director of Nursing or designee will educate all clinical staff on Safe Resident Handling with specific focus on required staff assistance by 8/16/2023. The Director of Nursing or designee will do lift observations 3x week for 12 weeks to ensure the transfer is completed according to the residents plan of care. If an issue is identified during the lift, the lift will be stopped and corrected as to prevent injury and the staff member will receive re-education. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months. The plan of correction may be changed or the audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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During an observation of the 100 hallway on 07/24/23 at 2:20 PM Resident #99 was observed in her room sitting in her wheelchair.

During a continuous observation of the 100 hallway on 07/24/23 at 2:25 PM Nurse Aide #5 was observed going into Resident #99's room with the mechanical lift. There were no other staff members observed entering the room with her.

On 07/24/23 at 2:34 PM upon entering Resident #99's room, Nurse Aide #5 was observed in Resident #99's room with the mechanical lift. Resident #99 was observed lying in her bed, with eyes closed and in no acute distress. There were no other staff members in the room.

During an interview on 07/24/23 at 2:35 PM Nurse Aide #5 stated that she went into Resident #99's room to put her in the bed because Resident #99 had been sitting up for a while and it was near the end of her shift. She stated she transferred Resident #99 from the wheelchair into the bed alone using the mechanical lift. She stated she had worked in the facility for over a year and had received training on using the mechanical lift and was aware that use of the mechanical lift required two person staff assistance. She stated, "I just didn't think to ask for help". She continued to say, "another staff person would have assisted her if she had asked them, and she should have asked." She stated Resident #99 did not fall during the transfer.

During an interview on 07/24/23 at 2:40 PM Nurse #1 stated she was Resident #99's assigned nurse. She stated Resident #99 required total care and the use of the mechanical

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F 689	Continued From page 25 lift for transfers. She stated the facility's policy was to use two-person assistance when transferring with the mechanical lift. She stated Nurse Aide #5 did not ask her for assistance before transferring Resident #99 alone, and indicated she was at the nurses station during that time and could have assisted Nurse Aide #5 with the transfer. She stated she was routinely assigned to Resident #99, and she has had no falls and her skin was intact. Review of Resident #99's medical record from July 2022 through July 2023 revealed no documented falls. During an interview on 07/24/23 at 2:50 PM the Director of Nursing (DON) stated the mechanical lift required 2 person staff assistance. He indicated all nursing staff had received training on using the mechanical lift. He stated Nurse Aide #5 should have asked for assistance before transferring Resident #99 alone. He stated further education would be provided.	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		8/21/23

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F 690	Continued From page 26 (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 observations, record review, Physician, Nurse Practitioners and staff interviews, the facility failed to obtain a physician order for an indwelling urinary catheter for 1 of 2 residents (Resident #146); and failed to determine and document an accurate diagnoses for the urinary catheterization for 2 of 2 residents (Resident #146 and #145) who had an indwelling urinary catheter. Findings included: 1. Resident #146 was admitted to the facility on 07/12/23. Diagnoses included, in part, stroke with right sided weakness. There was no	F 690	F690 Foley Catheters Resident #146 had a failed voiding trial on 8/11/2023. MD referred the resident to urology on 8/11/2023. The Foley catheter order was updated on 7/27/2023 with diagnosis of Urinary Retention. Resident #145 was admitted with Foley catheter for promotion of wound healing. Diagnosis of sacral osteomyelitis was added to the Foley catheter order on 7/27/2023. The Director of Nursing or designee with audit all residents with Foley catheters by 8/16/2023 to ensure each resident has an	

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F 690	Continued From page 27 diagnoses or justification recorded for an indwelling urinary catheter. A review of the discharge summary from the hospital dated 07/12/23 revealed there was no documentation to support why Resident #146 had an indwelling urinary catheter, A review of Resident #146's care plan dated 07/13/23 revealed there was no plan of care in place for an indwelling urinary catheter. The physician's urinary catheter orders written on 07/12/23 revealed an order to record urinary output each shift, change catheter as needed, anchor drainage bag and provide privacy bag. There was no order to indicate the size of the catheter, the catheter bulb size (amount of saline to fill the bulb to secure the catheter once inserted) or the justification. A review of the Catheter Justification assessment dated 07/12/23 completed by Nurse #12 revealed the indication that was checked off for catheter utilization was "resident requires due to prolonged immobilization." A review of the Evaluation for Continence and Retraining assessment dated 07/12/23 completed by Nurse #10 revealed the nurse answered "yes" for indwelling urinary catheter. The catheter size was recorded as 18 French and the catheter bulb size was recorded as 15 milliliters (ml). The supporting diagnosis for the purpose of the catheter was recorded as "urinary retention." A review of the admission progress note history and physical written by the facility Physician on 07/13/23 revealed the Physician was seeing	F 690	MD order for the Foley with an accurate diagnosis included in the order. Any issues identified will be corrected. The Director of Nursing or designee will educate all nurses, by 8/16/2023, on ensuring Foley catheter orders are entered on admission if applicable or once a new Foley has been inserted and that there is an accurate diagnosis for the Foley. The Director of Nursing or designee will audit all new admissions 5x week for 12 weeks to ensure any resident admitted with a Foley catheter has an order with an accurate diagnosis. The Director of Nursing or designee will also audit all Foley catheter orders weekly to ensure accurate orders are still in place. Any issues identified will be corrected and re-education will be provided to the nurse. Audits will be monitored by the Quality Assurance Performance Improvement committee for 3 months. The plan of correction may be changed or the audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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Resident #146 for a new admission and there was no mention of an indwelling urinary catheter in his assessment or plan.

The Minimum Data Set (MDS) admission assessment dated 07/18/23 revealed Resident #146 was severely cognitively impaired. She required extensive assistance with two person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and had an impairment to one side to upper and lower extremities Resident #146 had an indwelling urinary catheter and was always incontinent of bowel.

During an interview with Nurse #1 on 07/26/23 at 11:20 AM she stated Resident #146 was admitted to the facility from the hospital with the catheter for a wound. She stated usually if a resident was admitted with a urinary catheter the physician would give us the order to clamp off the catheter to see if the resident can void on their own or the physician would order a urology (a doctor who specializes in the urinary system) consult. Nurse #1 stated there was no urology appointment made at this time for Resident #146 and no order to clamp the catheter to see if Resident #146 could void. Nurse #1 stated if a resident came to facility from the hospital and there were orders for a catheter, they should be on the discharge summary indicating the size of the catheter, the bulb size and a diagnosis. She stated she did not admit Resident #146 but confirmed after reviewing the discharge summary, Resident #146 did not have orders for an indwelling catheter on the discharge summary and there was no mention of a wound. Nurse #1 stated she did not know why Resident #146 had a urinary catheter or what size she had. Nurse #1 reviewed the

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Evaluation for Continence and Retraining and noticed Nurse #10 had recorded Resident #146 had an indwelling urinary catheter for urinary retention with a catheter size 18 French and bulb size 15.

An observation of Resident #146's catheter with Nurse #1 was conducted on 07/16/23 at 11:30 AM. Nurse #1 noted Resident #146's catheter size was 16 French with 30 ml bulb.

At this time, Nurse #1 stated she would update the orders to include the correct catheter size and bulb size and stated it was important to have the accurate size recorded so staff would know what size to use when changing the catheter.

An interview was attempted via phone with Nurse #10 and Nurse #12 on 07/27/23 at 4:48 PM. Left messages for a returned call.

An interview was conducted with Nurse Practitioner (NP) #1 on 07/27/23 at 10:45 AM. NP #1 reported he had not seen Resident #146 since her admission, but if she had come in with a urinary catheter, he would expect for the nurses to notify him that she had a catheter and whether or not they should remove it especially if there was no indication for it in the discharge summary. NP #1 stated if the catheter was a necessity, he would expect the nursing staff to record the appropriate documentation to support why Resident #146 had it and to put the correct orders in place to care for the catheter. NP #1 stated there should have been a clinical diagnoses recorded for Resident #146's catheter as well as an order for the correct size catheter and bulb size.

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An interview was conducted with the facility Physician on 07/27/23 at 12:47 PM. The Physician reported he was aware Resident #146 had a urinary catheter. He reviewed the hospital discharge summary and confirmed there were no records to indicate why she had the catheter in place. The Physician stated if a resident was admitted with a urinary catheter he would want to do a voiding trial within a week. He added, if the catheter was not necessary, he would want to have it discontinued because it is a source of infection. The Physician stated there should be a clinical diagnosis recorded for any resident who had an indwelling urinary catheter and he should have questioned the nurses when he first assessed Resident #146 as to why she had the catheter. The Physician added he would have expected the nurses to input orders to include the correct catheter size and bulb size.

An interview with Nurse Practitioner #2 on 07/27/23 at 1:23 PM revealed that she did not see any documentation to support why Resident #146 had an indwelling urinary catheter in the discharge summary from the hospital. NP #2 stated usually there were standing orders for urinary catheters (batch orders) to include the size of the catheter and the bulb size. She would have expected the nurse to determine the correct sizes and document that in the orders.

An interview was conducted with the Director of Nursing (DON) on 07/27/23 at 1:50 PM. The DON stated he would have expected the nurses to determine why the resident had a urinary catheter and document the justification under the orders. The DON stated the nurses should ensure that all documentation related to the urinary catheter was accurate including the size

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of the catheter and the bulb size. The DON added the nursing staff need to take more time when completing their documentation so that they were entering accurate information.

An interview with another DON who was assisting the facility DON on 07/27/23 at 1:50 PM revealed the Evaluation for Continence and Retraining was a tool that was used for all residents including residents with a urinary catheter to determine if residents could void on their own and if there was a need for the catheter anymore. She stated the Foley Catheter Justification Form was important because it indicated on the assessment if the catheter was justified and why the resident should continue to need it.

2. Resident #145 was admitted to the facility on 7/13/23. Diagnoses included, in part, stage IV pressure ulcer to sacral region, urinary tract infection, and osteomyelitis of sacral region.

The discharge summary orders from the hospital dated 07/13/23 revealed, in part, to maintain catheter to keep wound clean and reduce risk of infection.

A review of the Catheter Justification assessment dated 07/13/23 completed by Nurse #11 revealed the indication that was checked off for catheter utilization was "resident had acute urinary retention or bladder outlet obstruction/obstructive uropathy diagnosis."

The Evaluation for Continence and Retraining assessment dated 07/13/23 completed by Nurse #11 revealed Resident #145 had an indwelling urinary catheter, 16 French with 5 ml bulb size

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and the supporting diagnoses was checked off as urinary retention.

A review of the care plan for Resident #145 revealed a plan of care was in place for pressure ulcer to the sacrum with a goal that pressure ulcer will show signs of healing and remain free from infection. The appropriate interventions were in place for the pressure ulcers. A plan of care was in place for intravenous therapy via a peripherally inserted central catheter (PICC) line with a goal that resident would be free of complications of infection. Intervention included, in part, assess/document/report to physician signs or symptoms of a urinary tract infection such as frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite and behavioral changes. There was no care plan in place for a urinary catheter.

A review of the physician orders for Resident #145's urinary catheter written on 07/13/23 revealed; urinary catheter size 16 French with 5 milliliter (ml) bulb, provide privacy cover for drainage bag, provide catheter care, maintain catheter drainage bag below bladder level, anchor catheter tubing and check placement every shift, record urinary output every shift, and change catheter as needed. There was no indication documented to support why Resident #145 had a urinary catheter.

The MDS assessment admission assessment dated 07/19/23 revealed Resident #145 was cognitively intact. She was coded as having an indwelling urinary catheter and a stage IV pressure ulcer upon admission.

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An interview with Nurse #11 on 07/27/23 at 11:50 AM revealed she was told in report from the hospital that Resident #145 had urinary retention so she documented urinary retention in the assessments. Nurse #11 reported when a resident was admitted to the facility, she would review the discharge summary orders and review them with the physician to determine which orders would be entered into the system. Nurse #11 stated she did not know why she did not put in the diagnosis after she initiated the catheter batch orders which indicated catheter size and bulb size and "must include diagnosis." She stated she could not remember why she did not enter it and added she did the admission, but "we do not have time to go through every single thing." Nurse #11 stated she missed reading Resident #145 had an indwelling urinary catheter due to a pressure ulcer in the discharge summary and stated, "I guess she has the catheter due to the pressure ulcer and not urinary retention."

An interview was conducted with Nurse Practitioner (NP) #1 on 07/27/23 at 10:45 AM. NP #1 reported the clinical diagnosis for the urinary catheter was written on the discharge summary and he would have expected the nurse to enter the diagnosis in the orders and to accurately complete the urinary catheter assessments to reflect the purpose of the catheter.

An interview was conducted with the Director of Nursing (DON) on 07/27/23 at 1:50 PM. The DON stated he would have expected the nurses to clarify the justification for the urinary catheter as to whether or not it was for urinary retention or due to a stage IV pressure ulcer and document

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F 690	Continued From page 34 the justification in the orders. The DON added the nursing staff need to take more time when completing their documentation to ensure they are entering accurate information. An interview with the assisting DON from another facility on 07/27/23 at 1:50 PM revealed the Evaluation for Continence and Retraining was a tool that was used for all residents including residents with a urinary catheter to determine if residents could void on their own and if there was a need for the catheter anymore. She stated the Foley Catheter Justification Form was important because it indicated on the assessment if the catheter was justified and why the resident should continue to need it.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		8/21/23

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F 692	Continued From page 35 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to obtain an accurate weight for a newly admitted resident (Resident #80) and failed to put interventions in place to prevent weight loss (Resident #38) for 2 of 5 residents reviewed for nutrition. Findings included: 1. Resident #80 was admitted to the facility on 04/07/23 with diagnoses that included, in part: Osteomyelitis, malignant neoplasm of lung and bronchus (cancer), secondary malignant neoplasm of the brain, moderate protein calorie malnutrition, pressure ulcer Stage 4 on sacrum, unstageable pressure ulcer on buttock, Stage 3 chronic kidney disease, benign prostatic hyperplasia, dementia and sepsis. Review of an admission MDS (Minimum Data Set) assessment dated 04/14/23 revealed Resident #80 required extensive to total assistance with all activities of daily living. He coughed or choked while swallowing. He had a weight loss. He was on a mechanically altered diet. He had (1) stage 4 pressure ulcer and (2) unstageable pressure ulcers present on admission. He had received opioid pain medication on one of the days during the assessment look back period. He had received Speech Therapy and Occupational Therapy on 5 days and Physical Therapy on 6 days during the assessment period. Review of the care plan for Resident #80 dated	F 692	F692 Nutrition/Hydration A new weight was obtained for resident #80 on 8/4/2023. The RD completed an assessment on 8/11/2023 and ordered magic cup with breakfast and lunch. A new weight was obtained for resident #38 on 8/4/2023. The resident was referred to the dietician for review on 8/14/2023. The Director of Nursing or designee will obtain a new weight on every resident in the facility by 8/16/2023. The IDT team will review the weights on 8/17/2023 to ensure appropriate interventions are in place for weight loss and refer to dietician as needed. The Director of Nursing and the other administrative nurses will be educated by the Regional Director of Clinical Services by 8/16/2023 on the weight policy and appropriate interventions for residents with weight loss. The Director of Nursing or designee will educate all nurses by 8/16/2023 on ensuring a new weight is obtained on admission and that the hospital weight not be used. The Director of Nursing will audit weights daily in the Clinical Morning Meeting 5x week for 12 weeks to ensure the facility is following the weight policy and that appropriate interventions are being put into place for residents with weight loss.	

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F 692	Continued From page 36 07/14/23 included the following focal area: Resident has increased nutrition/hydration risk related to: cancer, chronic kidney disease Stage 3, hypertension, protein-calorie malnutrition, and multiple wounds. The goal was for Resident #80 to be free of significant weight changes, and signs and symptoms of dehydration, fluid overload, and electrolyte imbalance through the next review. One of the interventions was to monitor his weight. The following weights were documented in the facility record for Resident #80: 04/07/23 at 4:11 PM: 153.00 pounds by bed scale 04/08/23 at 12:09 AM: 153.0 pounds by bed scale 04/10/23 at 10:58 PM: 127.0 pounds by Mechanical Lift Scale 04/18/23 at 10:22 AM: 128.0 pounds by Mechanical Lift Scale 04/25/23 at 3:24 PM: 129.0 pounds by Mechanical Lift Scale 05/02/23 at 1:50 PM: 129.0 pounds by Mechanical Lift Scale 06/02/23 at 8:11 AM: 132.0 pounds by Mechanical Lift Scale 07/05/23 at 2:47 PM: 138.0 pounds by Mechanical Lift Scale An interview was conducted on 07/16/23 at 1:35 PM with the Director of Nursing (DON) and the DON of a sister facility who was helping the newly appointed DON. The DON from the sister facility stated after investigating the weights that the nurse who admitted the resident had taken the resident's weight from the discharge paperwork from the hospital. She noted the weight of 153	F 692	The audit will be reviewed weekly in the resident review meeting and monthly in Quality Assurance Performance Improvement meeting for 3 months. The plan of correction may be changed or audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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pounds had been obtained at the hospital two months earlier on 02/11/23. She explained the facility did not have a bed scale. She stated the facility used a lift scale for residents if in bed and weights were obtained by the Restorative Aides (RA's) during the week, but the resident had been admitted on a Friday night when the RA's were off duty. The accurate admission weight of 127.0 pounds had been obtained by the RA's on Monday following the resident's admission. She stated any weights recorded in the facility record were to be weights done at the facility not obtained from records provided by another facility or hospital. She concluded no weights were to be documented in the facility records unless the weight was taken at the facility. She stated the weights documented on 04/07/23 and 04/08/23 would be stuck out as errors.

In an interview with the Restorative Aides on 07/27/23 at 10:00 they stated they did the weights at the facility and kept a 3-month manual record. They stated they did not have access to the weights in the computer system and used their manual record to determine weight loss or gain. They obtained the weights then reported them to the nurses who entered them into the computer system. They were not aware of the admission weight that had been documented so they did not know there was a >3 pound difference. They stated had they known, they would have reported it to the nurse and the Registered Dietician. They explained they reported any weight that varied by 3 pounds.

In an interview with Nurse #2 on 07/27/23 at 10:10 AM she stated she had entered the resident's weight into the system on 04/10/23 of 127 pounds. She explained she had worked

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second shift and the nurse on day shift had given her the weight to enter into the system because the day shift nurse had not had time. She stated she had not looked at the previous weights recorded and had not realized the difference in the weights.

A call was placed to Nurse #4 on 07/26/23 at 4:59 PM. She returned the call on 07/27/23 at 7:35 AM. She stated she recalled entering the weight for Resident #80 from the hospital records because she was too busy when he was admitted to weigh the resident. She concluded she should have weighed the resident instead of using the weight documented in the hospital records.

In an interview with the Administrator on 07/27/23 at 11:00 she stated staff was expected to weigh all residents on admission at the facility. She noted weights were not to be recorded that were from documents provided by other facilities.

2. Resident #38 was admitted to the facility on 7/13/20 with diagnoses which included acute kidney failure, and dementia.

Review of Resident #38's physician orders revealed an 8/10/22 physician order for regular diet with regular texture thin consistency liquids.

Review of the Registered Dietician (RD) evaluation on 8/15/2022 revealed Resident #38 received a regular diet with no adaptive equipment, no supplement was in place and consumed 51-100 percent of breakfast and lunch and 25-75 percent of dinner. The RD indicated Resident #38's meal intake was not meeting her nutritional needs and she was at risk for weight

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loss. The RD recommended Magic Cup supplement twice per day with lunch and dinner to meet the resident's estimated nutritional needs and staff were to monitor and record amount consumed.

Review of Resident #38's physician orders from 8/15/22-7/24/23 revealed no order for Magic Cup supplement with lunch and dinner was entered.

The following weights were documented in Resident #38's weight and vital sign record:
11/2/23 6:53 AM 189.0 pounds
12/2/22 7:23 AM 186 pounds
1/6/23 10:15 PM 190 pounds
2/3/23 3:28 PM 185 pounds
3/3/23 10:50 AM 181 pounds

Review of a Nurse Practitioner (NP) progress note on 3/14/23 indicated Resident #38 had a 10-pound weight loss recently. The Nurse Practitioner note did not include changes in care, new interventions and did not indicate that Resident #38 received a nutritional supplement.

On 4/10/2023 at 7:59 AM a weight of 177.0 pounds was recorded in Resident #38's weight and vital sign record.

Resident #38's 4/12/23 quarterly Minimum Data Set (MDS) assessment indicated resident had severe cognitive impairment with weight of 181# with no recent weight loss and was independent with supervision with eating.

On 5/5/2023 at 8:12 AM a weight of 172.0 pounds was recorded in Resident #38's weight and vital sign record.

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Review of Resident #38's physician progress note on 5/11/23 indicated resident was examined with no indication that resident's weight was addressed.

On 6/2/2023 at 8:00 AM a weight of 172.0 pounds was recorded in Resident #38's weight and vital sign record.
Review of a 6/29/23 swallowing evaluation revealed Resident #38 demonstrated mild to moderate oral dysphagia, difficulty swallowing food or liquids.

On 7/5/23 at 2:45 PM a weight of 164 pounds was recorded in Resident #38's weight and vital sign record.

Review of the NP progress notes revealed the resident was seen on 7/13/23. The note did not address Resident #38's weight loss, decreased intake, or the swallowing evaluation on 6/29/23 which indicated dysphagia.

Review of the RD evaluation on 7/17/2023 revealed Resident #38 received a regular diet with no nutritional supplement, had meal intake of 50-75 percent for breakfast and lunch and 25-50 percent for dinner with a weight of 164.0 pounds recorded on 7/5/2023. The RD indicated Resident #38 had significant weight change in the last 180 days with 13.7 percent weight loss in 6 months. The RD further stated that Resident #38's meal intake did not meet resident's needs, intake at dinner was decreasing and she was at risk for continued weight loss. The RD note indicated a recommendation for Boost supplement 240 milliliters twice per day to meet needs for weight maintenance and to prevent

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further weight loss.

Review of Resident #38's care plan revealed a nutrition problem was added on 7/17/23 which indicated actual weight loss of greater than 10 percent in 6 months with risk for further weight loss due to variable intake. Interventions indicated: assist with meals as needed, monitor amount taken of supplement/snack, record amount eaten on tray and weights per orders and as needed.

A physician order was entered on 7/17/23 for Resident #38 for Boost supplement twice per day.

Review of Resident #38's nursing progress notes revealed a note on 7/17/2023 at 4:40 PM which indicated a nutritional supplement was ordered to meet weight maintenance needs due to decreased intake and weight loss.

An interview was conducted on 7/27/23 at 10:20 AM with the Registered Dietician (RD). The RD revealed she reviewed residents based on acuity. The RD stated that she assessed a resident if they had a weight change, a wound, was a new admission, received tube feeding or quarterly if they were stable. The RD stated she reviewed the weight report that the Dietary Manager provided when she was in the facility. The RD stated she did not have access to any resident information when she was not in the facility. The RD stated she reviewed Resident #38 in August 2022 but had not followed up since regarding weight, supplement, or changes in intake. The RD stated she was not aware that Resident #38 had not received the magic cup supplement that she recommended in August 2022.

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An interview on 7/27/23 at 11:15 AM with the Dietary Manager revealed that the RD reviewed the weights. The Dietary Manager stated she ran a weight report and gave it to the RD for review on her scheduled visits. The Dietary Manager stated the RD completed assessments as needed on residents. The Dietary Manager stated the magic cup supplement was served on the meal trays and was not recorded on the Medication Administration Record. The Dietary Manager indicated that Resident #38 did not have an order for the magic cup supplement, and it was not served on her meal trays. The Dietary Manager did not know how the RD recommendations were processed.

An interview with the NP on 7/27/23 at 11:49 AM revealed that he did not recall being notified of Resident #38's recent significant weight loss, had not evaluated resident's weights, or ordered new interventions due to weight loss.

An interview on 7/27/23 at 11:30 AM with the Unit Manager#2 revealed that Resident #38 had declined in the past few weeks with decreased meal intake. The Unit Manager #2 indicated she thought the RD had been following Resident #38 for weight loss, but she was not sure. The Unit Manager #2 indicated the nurses on the floor were responsible for processing the RD recommendations including informing the family and physician of weight changes and obtaining orders for supplements.

Interview on 7/27/23 at 4:25 PM with the Director of Nursing revealed that he had only been in the position at the facility for a few months. He stated that he did not know why the magic cup supplement was not started and why

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F 692	Continued From page 43 interventions were not implemented to prevent further weight loss for Resident #38. An interview on 7/27/23 at 4:37 PM with the Administrator revealed that the RD evaluated residents as needed. The Administrator further indicated that RD recommendations were to be processed and interventions put in place as soon as possible after written.	F 692		
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. (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	F 732		8/21/23

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F 732	Continued From page 44 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 record review and staff interviews, the facility failed to post accurate nurse staffing information for 17 out of 26 days reviewed for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) from 07/01/23 through 07/26/23 was conducted. The staff posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00 PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility), a column for the number and actual hours worked, and a column for staffing totals. A review of the actual working assignment sheets compared to the daily staff posting sheets from 07/01/23 through 07/26/23 revealed 17 of the staff posting sheets were noted to have discrepancies of actual nursing staff that were physically in the facility working at the beginning of each shift including the RNs, LPNs, and CNAs.	F 732	F732 Staff Posting The staffing sheets from 7/1/2023 until 7/26/2023 were reviewed and corrected by the staffing coordinator on 8/14/2023. On 8/14/2023 the Staffing Coordinator reviewed all assignment sheets since 7/27/2023 to ensure the staff numbers and hours worked were accurate. The Director of Nursing or designee will educate all nurses, including the staffing coordinator by 8/16/2023 on ensuring the daily staff posting is adjusted throughout the day to reflect actual staff hours and the number of residents. The daily staff posting will be reviewed and audited by the Director of Nursing or designee 5x week for 12 weeks to ensure each once reflects the number of residents and any adjusted staffing. Any issues identified will be corrected and re-education will be provided to the nurse responsible. The audits will be reviewed by the Quality Assurance Performance	

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F 732	Continued From page 45 An interview was conducted with the Nurse Scheduler on 07/27/23 at 10:15 AM. She stated when she creates the staff postings, she records the number of staff that are scheduled. She noted that often the actual working schedule is different because staff call off or stay over and the nurses are supposed to change the numbers on the posting, but they haven't been doing it. She acknowledged the numbers are supposed to be the actual number of RNs, LPNs, and CNAs in the building at the start of a shift. In an interview with the Administrator on 07/27/23 at 11:00 AM she explained that the nurses had been changing the working schedules when staffing changed but had not been adjusting the staff postings when there was a discrepancy or change. She stated education would be provided to all the nurses regarding the staff posting and correcting it each shift to reflect the actual number of nurses and aides in the building at the start of each shift.	F 732	Improvement committee monthly for 3 months. The plan of correction may be changed or audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain a medication rate greater than 5% when a medication was administered after a meal instead of the physician order to give 30 minutes prior to	F 759	F759 Med Error rate >5% On 7/26/2023 resident #7 received her Spiriva after nurse #9 realized it had not been given. On 8/14/2023 the Medical	8/21/23

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F 759	Continued From page 46 a meal, and when one medication was omitted. The result of the medication errors could have resulted in a negative effect for 1 of 3 residents (Resident #7) observed for medication administration. The medication error rate was 8%. Findings included: Resident #7 was admitted to the facility on 06/08/21. Diagnoses included, in part, chronic obstructive pulmonary disease, and gastroesophageal reflux disease (GERD). On 07/26/23 at 8:45 AM a medication administration pass was observed with Nurse #9 for Resident #7. Nurse #9 was observed preparing the following medications for administration: Seroquel (antipsychotic) 25 milligrams (mg) one tablet, and 50 mg one tablet, Tramadol (medication to treat pain), 50 mg one tablet, Allopurinol (medication to treat Gout) 100 mg one tablet, Anastrozole (medication to treat breast cancer) 1 mg one tablet, Eliquis (medication to thin blood) 5 mg one tablet, Augmentin (medication to treat respiratory infection) 500-125 mg one tablet, Cardizem (medication to treat high blood pressure) 120 mg one tablet, Lasix (medication to treat congestive heart failure) 20 mg one tablet, Gabapentin (medication to treat pain) 300 mg one tablet, Namenda (medication to treat dementia) 10 mg one tablet, Glucophage (medication to treat diabetes) 850 mg one tablet, Metoprolol (medication to treat high blood pressure) 50 mg one tablet, Omeprazole (medication to treat GERD), 20 mg one tablet, Zoloft (medication to treat depression) 50 mg one tablet, and Thera gram (multivitamin) one tablet.	F 759	Director was notified that on 7/26/2023 the resident□s omeprazole was given after her meal. The resident was also made aware on 8/14/2023 that the admin time for her omeprazole had been changed to 0630. The Director of Nursing or designee will review all omeprazole orders by 8/16/2023 to ensure each order has an administration time prior to their meals. All alert and oriented residents will be interviewed by the Director of Nursing or designee by 8/16/2023 to ensure there are no issues with the resident receiving their scheduled medications. All issues will be addressed and reported to the MD if necessary. The Director of Nursing or designee will educate all nurses by 8/16/2023 on the 5 rights of medication administration and will complete a medication administration competency on each nurse. The Director of Nursing or designee will complete 3 medication administration competencies a week for 12 weeks to ensure medications are administered correctly and per the physician orders. Any issues will be reported to the MD and the nurse will receive immediate re-education. The audits will be reviewed by the Quality Assurance Performance Improvement committee for three months. The plan of correction may be changed or the audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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a. On 07/26/23 at 8:52 AM Nurse #9 was observed administering the medications she prepared for Resident #7. Resident #7 was noted to have swallowed all the medications that Nurse #9 handed her. Resident #7's breakfast tray was noted to be in front of her on her bedside table. The breakfast tray was noted to be 100% consumed.

An interview with Resident #7 at 8:52 AM revealed she had just finished eating her breakfast.

An interview with Nurse #9 at 8:53 AM revealed she had completed her medication administration for Resident #7 and had given all of the resident's morning medications as scheduled. Nurse #9 reported Resident #7 had just finished eating her breakfast.

A review of the physician medication orders during reconciliation on 07/26/23 at 9:30 AM, it was noted the physician's orders revealed Omeprazole 20 mg one capsule per day to be administered at least 30 minutes before a meal.

An interview with Nurse #9 on 07/26/23 at 10:15 AM was conducted. Nurse #9 reviewed the medication administration record (MAR) at this time and stated she should not have given the Omeprazole because the order read to give at least 30 minutes before a meal and confirmed Resident #7 had just finished her meal at the time of the administration.

An interview was conducted with Nurse Practitioner (NP) #1 on 07/27/23 at 10:45 AM. The NP revealed Omeprazole was recommended

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to be given on an empty stomach so the effects of the medication can begin to work before a resident starts eating. The NP stated he would have expected the nurses to ensure to the order was put into the system at a time when a meal was going to be given 30 minutes or later.

An interview was conducted with the Director of Nursing (DON) on 07/27/23 at 1:50 PM. The DON stated that nurses should be following the physician orders and administering the Omeprazole 30 minutes before a meal.

b. On 07/26/23 at 8:52 AM, Nurse #9 was observed administering the medications she prepared for Resident #7. Resident #7 was noted to have swallowed all the medications that Nurse #9 handed her.

An interview with Nurse #9 at 8:53 AM revealed she had completed her medication administration for Resident #7.

A review of the physician medication orders during reconciliation on 07/26/23 at 9:30 AM, it was noted Nurse #9 had omitted giving Resident #7 the physician ordered Spiriva (a medication to treat COPD) one capsule daily.

An interview with Nurse #9 on 07/26/23 at 10:15 AM was conducted. Nurse #9 reported she usually removed the Spiriva medication from the drawer once she had all of Resident #7's oral pills in a cup and would give it to Resident #7 once she had taken all of her medications from the cup. Nurse #9 stated she forgot to remove the Spiriva from the drawer and realized it was not given until she went back into the system to check it off. Nurse #9 reported she knew which

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F 759	Continued From page 49 medications were ordered for Resident #7 by memory and she followed the medication administration record and reviewed the orders, but somehow she missed the Spiriva. An interview was conducted with the Director of Nursing (DON) on 07/27/23 at 1:50 PM. The DON reported the nurses should be reviewing each residents' MAR during the medication pass to ensure they were not omitting any physician ordered medications.	F 759		
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	F 761		8/21/23

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F 761	Continued From page 50 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a medication cart on the 400 Hall when the medication cart was noted to be in an unlocked position and the keys to the medication cart were inserted in the drawer where narcotics were kept for 1 out of 4 medication carts observed. Findings included: A continuous observation of a medication cart on the 400 Hall at 11:45 AM until 12:05 PM on 07/24/23 revealed the medication cart was facing the hallway and was unlocked with the keys to secure the cart and the narcotic drawer were observed hanging from the lock of the narcotic drawer. Nurse #9 was not in view. During the observation, a therapist and a resident in a wheelchair were adjacent (approximately 2 feet away) to the cart for 20 minutes, a family member with a resident in the wheelchair walked by the cart twice, two nurse aides walked by the cart, and a resident in a wheelchair was parked in front of the cart for 10 minutes while waiting for the nurse. An interview with Nurse #9 on 07/24/23 at 12:05 PM when she returned to the medication cart revealed she got pulled away and distracted and she left the keys in the narcotic drawer and left the medication cart unlocked. She stated she "messed up" and she "got distracted." She stated she knew she was supposed to lock her cart and keep her keys on her person anytime she walked away from the cart.	F 761	F761 Medication Storage The cart was locked and secured by the nurse on 7/24/2023. The nurse counted her narcotics at the end of the shift with no discrepancies noted. The Director of Nursing did a walkthrough of the facility on 7/27/2023 to ensure there were no other unlocked medication carts. There were no other issues identified. Education will be provided to all nurses by 8/16/2023 by the Director of Nursing on medication storage with special focus on unlocked medication carts. The Director of Nursing or designee will do a visual inspection 5x week for 12 weeks to ensure medication carts are being secured when not in use and not within sight of the nurse. Issues will be corrected immediately and the nurse will receive immediate re-education and/or disciplinary action after the first correction. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months. The plan of correction may be changed or audits extended to ensure ongoing compliance. Audits will begin 8/17/2023.	

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F 761	Continued From page 51 An interview with the Director of Nursing (DON) on 07/27/23 at 2:50 PM revealed any time nursing staff walk away from their medication cart, they should be sure the cart was secured and the keys to their cart were on their person. He stated leaving a medication cart unsecured and unsupervised was not safe and staff, family, or residents could access the medication cart.	F 761		
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,	F 867		8/21/23

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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

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

§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;

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consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI 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;

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F 867	Continued From page 54 (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, record review and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a recertification and complaint investigation on 03/03/22 for one deficiency that was originally cited in area of nutritional maintenance (F692). This deficiency was subsequently recited on the current recertification and complaint survey on 07/27/23. The continued failure during 2 surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F692: Based on observations, record review and staff interviews the facility failed to obtain an accurate weight for a newly admitted resident and failed to put interventions in place to prevent weight loss. During a recertification and complaint survey on 03/03/22, the facility failed to follow a renal diet for a resident reviewed for dialysis. An interview was conducted with the Administrator on 07/27/23 at 4:07 PM. The Administrator revealed she sensed the nutrition concerns were not a system breakdown as the	F 867	F867 QA A new weight was obtained for resident #80 on 8/4/2023. The RD completed an assessment on 8/11/2023 and ordered magic cup with breakfast and lunch. A new weight was obtained for resident #38 on 8/4/2023. The resident was referred to the dietician for review on 8/14/2023. The Director of Nursing or designee will obtain a new weight on every resident in the facility by 8/16/2023. Any resident with weight loss will be referred to the RD and reviewed by the Interdisciplinary team to ensure interventions are in place. The Regional Director of Clinical Services will educate the Facility Administrator and the Director of Nursing by 8/16/2023 on QAPI at a glance as well as the QAPI policy. To ensure ongoing compliance the Regional Director of Clinical Services or the Regional Vice President of Operations will participate in the monthly QA meeting for three months.	

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F 867	Continued From page 55 concerns were isolated and not widespread and added that continued education and training would be done.	F 867		