STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/10/23 through 07/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # UJUK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/10/23 through 07/13/23. Event ID# UJUK11. The following intakes were investigated: NC00194629, NC00195096, NC00195857, NC00196483, NC00196577, NC00197232, NC00197349, NC00197467, NC00198248, NC00198261, NC00200438 and NC00200823. 13 of the 28 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		8/8/23

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

Electronically Signed | 08/04/2023

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to maintain a resident's dignity by not answering a call light and allowing the resident to sit on the floor for an extended period causing Resident #31 to feel "afraid", "neglected", shaky, and upset. This occurred for 1 of 8 residents reviewed for dignity (Resident #31). Findings included: Resident #31 was admitted to the facility on 7-30-21.	F 550	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 31 was assisted back to bed by staff members. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 550	Continued From page 2 The quarterly Minimum Data Set (MDS) dated 6-16-23 revealed Resident #31 was moderately cognitively impaired. Transfers did not occur. Resident #31 was interviewed on 7-10-23 at 12:08pm. The resident discussed having a fall in May 2023 or June 2023 in the "middle of the night." The resident discussed how she had put her call light on to be assisted into bed, but she stated after waiting 30 minutes, she decided to try and transfer herself. She stated she forgot to lock her wheelchair and as it started rolling, she tried to sit back down but sat on the edge of the wheelchair. Resident #31 explained she was holding on to one of the arms on the wheelchair and the side rail of the bed. She stated her call light was still on. Resident #31 stated she sat in that position for an hour before staff answered her call light. Resident #31 stated she knew the time because she had looked at the clock on her wall. The resident continued to explain once staff had answered her call light, the nurse (Nurse #3) was unable to assist her back into bed, so the nurse lowered her to the floor, and she had to wait another hour on the floor until Nurse #3 was able to find assistance to help her back to bed. The resident stated she felt "afraid" and "neglected." A telephone interview occurred with Nurse #3 on 7-12-23 a 3:04pm. The nurse discussed she had answered Resident #31's call light on 5-20-23 and when she walked into the resident's room, she had found the resident sitting on the edge of her wheelchair with her buttocks almost touching the floor. Nurse #3 stated she could not say how long the resident's call light had been on. Nurse #3 continued to explain she was unable to	F 550	All Residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 08/02/23 the facility Administrator reinitiated the expectation for the use of Walkie Talkies for all clinical staff to carry for emergency usage. Clinical Nursing staff education began on 08/02/23 by the Clinical Competency Coordinator and Nurse Management staff on the use of Walkie Talkies within the facility for Resident emergencies. This education has been added to the general orientation of all newly hired clinical staff to include Nurses and Certified Nursing Assistants. Clinical Nursing Staff not educated by August 3rd , 2023 will be removed from the schedule until education on Walkie Talkies is completed. The Director of Health Services and/or Nurse Mangers are conducting a review to ensure all clinical staff have Walkie Talkies on their person daily for five days then twice a week for four weeks then weekly for three months until three months of sustained compliance is maintained then quarterly thereafter. On 08/04/23 the Facility Management Team (Administrator, Director of Health Services, Social Worker, Activities Director, Maintenance Director,	

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F 550	Continued From page 3 transfer the resident into the bed or back into the wheelchair, so she lowered Resident #31 to the floor. She stated the resident was "shaky" and "upset." The nurse discussed leaving the resident's call light on but stated when no one was coming to help, she sent Resident #31's roommate out to look for help. Nurse #3 said the roommate could not find anyone, so she left the room and was able to find Nursing Assistant (NA #5) to assist in getting Resident #31 back to bed. She stated "it took a while" to get the resident back to bed but said she did not think it was quite an hour. NA #5 was interviewed by telephone on 7-13-23 at 8:27am. NA #5 stated he was not present when Resident #31 fell but had been asked by Nurse #3 to go to Resident #31's room and assist in placing her back in the bed. The NA stated the resident was cold and had asked for a blanket, but he said he picked her up and placed her back in bed then covered her with her blankets. During an interview with the Director of Nursing (DON) on 7-13-23 at 10:12am, the DON discussed the facility policy of everyone answering call lights. She stated she was aware Nurse #3 had to lower the resident to the floor, but not aware Resident #31 had waited an hour for assistance when she was on the edge of her wheelchair or that the resident laid on the floor for an hour waiting for Nurse #3 to find assistance. The DON stated she expected staff to be answering call lights as soon as possible. The Administrator was interviewed on 7-13-23 at 12:17pm. The Administrator discussed staff carrying walkie talkies so they can request help when needed and stated she did not know why	F 550	Environmental Service Director, Financial Counselor, Admissions Director, and Nurse Managers, began reviewing the call light response time by visual viewing when a call light was placed on and when a staff member answered the call light. This process occurs on all shifts to ensure proper call light answering response time. This visual review will occur daily for 7 days, then weekly for four weeks, then monthly until three months of sustained compliance is maintained then quarterly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will present the analysis of the Walkie Talkie audit to the Administrator at the Monthly Quality Assurance and Performance Improvement Committee for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. The Administrator will present the call light analysis at the Monthly Quality Assurance and Performance Improvement Committee for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. "Include dates when corrective action will	

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F 550	Continued From page 4 Nurse #3 had not used her walkie talkie on 5-20-23 when Resident #31 had fallen. She also commented that she could not say why it took an hour for staff to answer Resident #31's call light. The Administrator explained there was a system in place (the walkie talkies) for staff to ask for assistance and if the employees had worked the process/system it should have only taken 5-7 minutes to get Resident #31 back in bed. She also stated she expected staff to answer call lights as soon as possible.	F 550	be completed. " August 8 2023	
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		8/8/23

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F 580	Continued From page 5 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP), and Medical Doctor (MD) interviews, the facility failed to notify the MD of the resident's medication refusals for 1 of 1 resident (Resident #11) reviewed for notification. Findings included: Resident #11 was admitted to the facility on 4/23/20 with diagnoses which included anxiety, depression, hypothyroidism, schizoaffective disorder, gastroesophageal reflux disease, constipation, and hyperlipidemia.	F 580	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 07/10/23 the Medical Director and Nurse Practitioner was updated on the resident refusal of medication. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 08/02/23 the Director of Health	

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F 580	Continued From page 6 Review of Resident #11's quarterly Minimum Data Set dated 5/10/23 revealed the resident had severe cognitive impairment and was coded for rejection of care 1 to 3 days during the 7 day look back period. Review of Resident #11's July 2023 Medication Administration Record (MAR) revealed she had 9 medications scheduled for 8:00 AM, 8:00 PM, or both times. Of these scheduled medications for July 2023, she had a refused all her medications for 10 days except for two 8:00 PM evenings doses on July 5 and 6. These medications included psychiatric, hyperlipidemia, thyroid, stomach reflux, insomnia, and constipation medications. An interview on 7/11/23 at 12:21 PM with Nurse #1 revealed she was frequently assigned to provide care for Resident #11. She stated she thought the NP and MD were aware of the resident's medication refusals, but she had not notified them. An interview on 7/11/23 at 12:26 PM with the MD revealed she was unaware of Resident #11 medication refusals. She stated that the facility typically should have notified her or the NP if the resident refused medications more than 3 days. An interview on 7/11/23 at 2:22 PM with the Director of Nursing (DON) revealed she was unaware that the NP or MD had not been notified of Resident #11's medication refusals. She stated the NP or MD should be notified if the resident refused medications. An interview on 7/12/23 at 11:54 AM with the NP revealed she had not been notified of Resident	F 580	Services and Nurse Managers conducted a review of all resident medication administration record for the past 30 days, to identify any other resident refusing medications. 27 of 90 residents were noted to have repetitive medication refusals. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers began educating all Licensed Nurses on Physician / Physician Extender notification for Residents refusing medications. Any Licensed Nurse not educated by August 4, 2023, will be removed from the schedule until the education is completed. This education regarding Physician / Physician Extender Notification has been added to the general orientation for all newly hired Licensed Nurses. The Director of Nursing and / or Nurse Managers will review the Medication Administration report for residents that are refusing medications to ensure the physician and / or Physician extender was notified of the residents refusal. This medication administration review for residents refusing their scheduled medications will occur weekly for four weeks then monthly until three months of sustained compliance is maintained then quarterly.	

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F 580	Continued From page 7 #11's medication refusals. She stated she was aware the resident refused medications at times in the past but was unaware the residents had refused medications consistently for the past 10 days. The NP stated that she did not think she would have 'changed much of anything' but may have contacted psychiatry for a referral earlier if she had known about the medication refusals. An interview on 7/12/23 at 2:04 PM with the Administrator revealed she was unaware that the NP or MD had not been notified of Resident #11's medication refusals. She stated the resident's refusals had become 'normalized' and the staff failed to notify the NP or MD.	F 580	"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained, a The Director of Health Services will present the analysis of the medication administration refusal review to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. "Include dates when corrective action will be completed. August 8, 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, 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	F 600		8/8/23

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F 600	Continued From page 8 by: Based on record review and resident, staff, and resident representative interviews the facility failed to protect Resident #8's right to be free from abuse for 1 of 3 sampled residents reviewed for abuse (Resident #8). On an unknown date in October 2022, Nursing Assistant (NA) #7 was witnessed by NA #8 to have grabbed hair on the top of Resident #8's head and pulled the resident's hair after Resident #8 had allegedly made derogatory statements to NA #7. A reasonable person would have experienced feelings such as intimidation, fear, humiliation, embarrassment, and/or dehumanization (deprivation of human qualities such as compassion). Findings included: Resident #8 was admitted to the facility on 1-31-22 with multiple diagnoses that included vascular dementia. The quarterly Minimum Data Set (MDS) dated 8-1-22 revealed Resident #8 was severely cognitively impaired. The facility's 24-hour initial report dated 10-24-22 written by the Administrator documented approximately two weeks ago NA #7 was observed pulling Resident #8's hair. The facility's 5-day report dated 10-27-22 written by the Administrator documented on the morning of 10-24-22 an initial allegation was made that NA #7 had been observed pulling Resident #8's hair. The 5-day report documented the allegation had been substantiated and Resident #8's representative had been notified.	F 600	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility submitted the allegation of abuse to the Department of Health Services Registry on 10/24/2022 when the facility management staff was made aware of the allegation. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 08/01/23 the Director of Nursing, Clinical Competency Coordinator and/or Nurse Managers began education to all staff on Abuse prevention, Identification and with focus on Reporting any alleged abuse in a timely manner (immediately) to the Administrator, Director of Nursing and their immediate supervisor. Staff members not educated by August 4th, 2023, will be removed from the schedule until the education has been completed. The education on prevention, Identification and Reporting has been added to the general orientation for all newly hired employees.	

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F 600	Continued From page 9 On 7-10-23 at 1:57pm Resident #8 was interviewed. The resident stated she did not remember the incident back in October 2022 and said she had not been hurt by any staff members. Resident #8's representative was interviewed by telephone on 7-11-23 at 8:35am. The representative stated Resident #8 had severe dementia and would not have remembered the incident. She stated the Administrator had notified her NA #7 had pulled Resident #8's hair "hard." The representative discussed seeing Resident #8 a "few days" after she was informed of the incident and stated Resident #8 was "fine" and could not remember the incident. NA #8 was interviewed by telephone on 7-11-23 at 2:26pm. NA #8 confirmed she had been orienting with NA #7 in October 2022 when the incident occurred but stated she could not remember the exact date. The NA discussed entering Resident #8's room with NA #7 to place Resident #8 back in bed. She stated she did not hear Resident #8 make any derogatory remarks to NA #7 but saw NA #7 grab Resident #8's hair on the top of her head and pull it. She stated Resident #8 said "ow". NA #8 explained what she had said to NA #7 "I didn't think we were allowed to do that" and stated she walked out of the room. During a telephone interview with NA #9 on 7-11-23 at 3:55pm, the NA discussed not witnessing the incident but explained NA #7 had told her about the incident. NA #9 explained it was her second night of orientation with NA #7 and they were on break when NA #7 told her Resident #8 called her the "N" word. She stated NA #7 told her she got "so mad" and pulled	F 600	The facility has posted reporting requirements and phone numbers at each nursing station, dietary department, environmental services office and Therapy office for reference and notification to the Administrator. On 08/01/23 the Director of Nursing, Clinical Competency Coordinator and/or Nurse Managers began education to all staff on being aware of their own indicators of stress and frustration; recognize when to step away to avoid negative interactions during care. Staff members not educated by August 4th, 2023, will be removed from the schedule until the education has been completed. This education has been added to the general orientation for all newly hired employees. The Human Resource Director will conduct five resident interviews and/or observations weekly for 12 weeks related to abuse and neglect. Residents unable to verbalize answers will be observed for signs and symptoms of abuse (bruising, fearfulness, shying away from staff, etc.) any concerns will be immediately reported to the Administrator. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator will present the analysis of the abuse interviews of the alert and oriented residents and nonverbal	

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F 600	Continued From page 10 Resident #8's hair, then left the room to obtain hot sauce. NA #9 stated NA #7 told her when she returned to Resident #8's room, she had put the hot sauce on a wet wipe and wiped Resident #8's vagina. An interview with Nurse #5 occurred on 7-12-23 at 10:07am. Nurse #5 stated she performed the skin assessment on 10-24-22 and found no abnormalities. A telephone interview occurred with NA #10 on 7-12-23 at 10:42am. NA #10 explained she had been in Resident #8's room with NA #7 and NA #8 in October 2022 "it was either the 17th, 19th, or 21st of October." The NA stated she had been providing care to Resident #8's roommate when she heard Resident #8 say "ouch you're hurting me." She stated by the time she looked over towards Resident #8, she did not see anything happening. NA #10 discussed seeing NA #8 walk out of the room looking "very upset" but said she did not know why. An attempt was made to contact NA #7 but there was no working phone number available. The DON was interviewed on 7-12-23 at 10:17am. The DON discussed on 10-24-22 at 8:00am when she came to work, the previous Human Resource Coordinator had informed her NA #7 had been calling saying staff were accusing her of putting hot sauce in Resident #8's brief. The DON stated when she interviewed NA #8, the NA told her NA #7 had "grabbed" Resident #8's hair on the top of her head and pulled the hair down towards the resident's face. She stated she also interviewed NA #10, who was present in the room but did not say she saw NA #7 pull	F 600	residents observations for (bruising, fearfulness, shying away from staff, etc,) to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. " Include dates when corrective action will be completed. " August 8, 2023	

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F 600	Continued From page 11 Resident #8's hair. The DON explained none of the employees could say what day the incident occurred, but she had narrowed down the time frame through NA #8's orientation schedule to be within two weeks prior to 10-24-22.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced	F 607		8/8/23

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F 607	Continued From page 12 by: Based on record review, resident, and staff interviews, the facility failed to implement their abuse policy and procedure in the area of reporting when Nursing Assistant (NA) #8, NA #9, and NA #10 did not immediately report an allegation of abuse between a staff (NA #7) member and a resident (Resident #8) resulting in a lack of protection for Resident #8 and other facility residents. The facility also failed to report to the state agency within the required two-hour time frame. This occurred for 1 of 1 resident (Resident #8) reviewed for abuse. Findings included: The facility's "Abuse Identification" policy and procedure reviewed on 12-7-22 revealed in part patients/residents in a health care center should not be subjected to abuse or neglect by anyone including staff and any person observing, hearing a complaint of, and/or identifying any signs and symptoms of abuse, corporal punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property, or exploitation should report it to the Administrator as soon as possible. The facility's "Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of property" policy and procedure reviewed 12-7-22 revealed in part the state survey agency should be notified in accordance with state law of any allegations of abuse, neglect, exploitation, or mistreatment within two-hours after the allegation is made. Resident #8 was admitted to the facility on 1-31-22.	F 607	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility submitted the allegation of abuse to the Department of Health Services Registry on 10/24/2022 when the facility management staff was made aware of the allegation. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 08/01/23 the Director of Nursing, Clinical Competency Coordinator and/or Nurse Managers began education to all staff on Abuse prevention, Identification and with focus on Reporting any alleged abuse in a timely (immediately) manner to the Administrator, Director of Nursing and their immediate supervisor. Staff members not educated by August 4th, 2023, will be removed from the schedule until the education has been completed. The education on prevention, Identification and Reporting has been added to the general orientation for all newly hired employees.	

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F 607	Continued From page 13 The quarterly Minimum Data Set (MDS) dated 8-1-22 revealed Resident #8 was severely cognitively impaired. The facility's "24-Hour Initial Report" dated 10-24-22 written by the Administrator documented that on 10-24-22 at approximately 3:45pm an allegation of staff to resident abuse. NA #7 had been observed by NA #8 pulling a resident's hair (Resident #8) about two weeks ago. A timeline of the staff to resident abuse allegation dated 10-27-22 written by the Administrator revealed on 10-24-22 at 8:45am the previous Human Resource Coordinator informed the Director of Nursing (DON) that the alleged perpetrator (NA #7) contacted her and reported she heard staff in the break room accusing her of putting hot sauce in a resident's brief and pulling Resident #8's hair. The previous Human Resource Coordinator was interviewed by telephone on 7-12-23 at 10:53am. The previous human Resource Coordinator stated NA #7 had called her on 10-24-22 at 8:00am to report that she was being accused of putting hot sauce in a resident's (Resident #8) brief and pulling her hair. She stated she did not question NA #7 as to when the incident occurred but had provided the information from NA #7 to the DON. Resident #8 was interviewed on 7-10-23 at 1:57pm. The resident stated she did not remember the incident in October 2022 and said no staff had ever physically hurt her.	F 607	The facility has posted reporting requirements and phone numbers at each nursing station, dietary department, environmental services office and Therapy office for reference and notification to the Administrator. The Social Worker will review the 24-hour report and the Reportable Incident Log weekly times twelve weeks to audit for timely reporting of any allegations, this includes immediate notification to the Administrator or designee, and was the initial report and five day report completed within the federal regulation timeframe; any variance will be immediately reported to the Administrator for correction. The Social Worker will provide a report at the monthly QAPI meeting of weekly audit outcomes. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; a The Administrator will present the analysis of the abuse reporting process to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. "Include dates when corrective action will be completed.	

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F 607	Continued From page 14 NA #8 was interviewed by telephone on 7-11-23 at 2:26pm. The NA stated she was present when NA #7 had pulled Resident #8's hair but said she did not know anything about hot sauce being placed in Resident #8's brief. She discussed that she had been a new employee at the time and was orienting with NA #7 and stated the incident happened around the middle of October 2022 but said she could not remember the exact date. NA #8 discussed after NA #7 had pulled Resident #8's hair, she walked out of the room but did not report the incident. The NA stated she did not know who to report the incident to. NA #8 revealed NA #7 continued to work the remainder of the shift providing resident care. A telephone interview occurred with NA #9 on 7-11-23 at 3:55pm. The NA explained she was not present when the incident occurred. NA #9 explained she had been orienting with NA #7 when NA #7 informed her she had been angry with Resident #8 so she pulled the resident's hair while putting the resident in the bed and then left the resident room, obtained some hot sauce, went back into the resident's room and while cleaning Resident #8, NA #7 placed hot sauce on the wipe and wiped Resident #8's vagina. NA #9 stated she believed the incident occurred around the end of September 2022 or the beginning of October 2022 because NA #7 stated it was "a couple weeks ago" that she become angry with Resident #8. NA #9 stated she was "shocked" and not sure if the information was true, so she did not report the incident to anyone. An interview with NA #10 occurred by telephone on 7-12-23 at 10:42am. NA #10 explained she was in the room when the incident with Na #7 and Resident #8 occurred but did not see anything.	F 607	"August 8, 2023	

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F 607	Continued From page 15	F 607		

She stated she had heard Resident #8 say "ow" but said by the time she looked she did not see NA #7 doing anything. NA #10 discussed the incident occurring around October 17, 19, or 21, of 2022 but could not remember the exact date. She also discussed not reporting the incident to anyone because she did not see anything.

During an interview with the DON on 7-13-23 at 10:26am, the DON stated the staff had been educated in reporting abuse immediately to the Administrator and was not sure why the incident had not been reported before 10-24-22. The DON stated she did not know when the last education on abuse occurred with staff but stated it was prior to the incident with NA #7 and Resident #8. She stated she expected all staff to report any abuse immediately to a manager and/or the Administrator. The DON also discussed being aware that the 24-hour report had to be submitted to the state agency within two hours but stated since it was not clear as to what happened an investigation had to be completed first. She verified that she was made aware of the allegation by the previous Human Resources Coordinator on 10-24-22 at approximately 8:45 AM and the 24-hour report was not submitted until approximately 3:45pm.

The Administrator was interviewed on 7-13-23 at 12:31pm. The Administrator discussed the facility's process for reporting abuse. She explained part of the facility's process included staff education which encompassed when to report abuse and who to report the abuse to. The Administrator stated she believed the facility's process worked even though the incident with Resident #8 had not been reported for approximately 2 weeks and stated the incident

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F 607	Continued From page 16 was not reported because of the relationships between the NAs. She verified NA #7 had worked after the incident providing resident care until NA #8 had reported the allegations against her to HR on 10/24/22. She explained she was aware the 24-hour report needed to be sent to the state agency within a two-hour time frame but stated the situation was unclear and she needed to conduct interviews and investigate before completing the 24-hour report. The Administrator stated she expected staff to report any incidences of possible abuse immediately.	F 607		
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 accurately code anticoagulant medication use on a Minimum Data Set (MDS) assessment for 2 of 6 residents reviewed for unnecessary medications (Resident #48 and Resident #44). Findings included: 1. Resident #48 was admitted to the facility on 1/30/23. Her active diagnoses included hypertension, diabetes mellitus, hyperlipidemia, and stroke. Review of Resident #48's orders on 7/11/23 at 9:03 AM revealed Resident #48 was not ordered an anticoagulant.	F 641	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 48 and # 44 Minimum Data Set (MDS) has been modified to the correct coding on 07/11/23. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Case Mix Director and Case Mix Coordinator conducted a 100% review of all MDS□s of residents receiving Plavix (clopidogrel). Out of 6 Resident 6 required modification to the MDS.	8/8/23

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F 641	Continued From page 17 Review of Resident #48's quarterly MDS assessment dated 5/8/23 revealed Resident #48 was severely cognitively impaired and coded to have received an anticoagulant 3 days of the lookback period. Review of Resident #48's medication administration record revealed the resident did not receive an anticoagulant during the lookback period. Resident #48 received Plavix on 3 days of the lookback period. During an interview on 7/11/23 at 3:32 PM the MDS Coordinator stated she was told to code Plavix as an anticoagulant but had no documentation of this. Resident #48 was on Plavix during the lookback period and refused the medication for 4 days during the lookback period; therefore, Plavix was coded as an anticoagulant for 3 days on the 5/8/23 quarterly MDS assessment. During an interview on 7/11/23 at 3:51 PM the Administrator stated she was unsure what the MDS process was but expected the MDS nurses to follow MDS guidelines to accurately code the MDS. 2. Resident #44 was admitted to the facility on 8/29/22 with diagnoses which included hypertension and rheumatoid arthritis. Review of Resident #44's physician orders dated 8/29/22 revealed an order for clopidogrel (Plavix) 75 milligrams once a day for heart disease. Review of Resident #44's quarterly Minimum Data Set (MDS) dated 6/07/23 revealed the resident had moderate cognitive impairment and	F 641	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Case Mix Director provided education to the Case Mix Coordinator on 08/02/23 regarding the utilization of the RAI manual for coding the MDS. This education has been added to the general orientation of newly hired Case Mix Coordinators. The Case Mix Director will complete a weekly audit of five MDS□s completed by the Case Mix Coordinator. The Case Mix Coordinator will complete a weekly audit of five MDS□s completed by the Cas Mix Director. Any inaccuracies will be corrected at the time of the review. These audits will continue weekly for twelve weeks then monthly thereafter. The Case Mix Director will maintain a log of any identified miscoding□s and corrections made and track and trend the information. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Case Mix Director will present the analysis of the miscoding log to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan.	

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F 641	Continued From page 18 was coded as receiving an anticoagulant 7 days during the 7-day look back period. Review of Resident #44's care plan last revised on 6/12/23 revealed she was care planned for anticoagulation usage and no diagnosis was noted. Review of Resident #44's medication administration record revealed no anticoagulant administration during the 7-day look back period. An interview on 7/11/23 at 3:32 PM with the MDS Director and MDS Coordinator revealed the MDS Coordinator had been told to code Plavix as an anticoagulant. She stated she had no documentation related to coding Plavix as an anticoagulant. The MDS Director stated that Plavix was not to be coded as an anticoagulant. An interview on 7/11/23 at 3:51 PM with the Administrator revealed she was unsure what the MDS process specifically was, but expected the MDS nurses to follow the MDS guidelines to accurately code the resident's MDS.	F 641	Include dates when corrective action will be completed. August 8, 2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		8/8/23

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F 657	Continued From page 19 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update the care plan to accurately reflect the code status (Resident #73 and Resident #76) and the current diet order (Resident #76) for 2 of 25 residents whose care plans were reviewed. Findings included: 1. Resident #73 was admitted to the facility on 12/15/22 with diagnoses including stroke. A review of Resident #73's admission form dated 12/18/22 revealed Resident #73 had not executed and advanced directive and did not want to discuss advanced directives further at that time. It further indicated Resident #73 did not have a Do Not Resuscitate (DNR) or Medical Orders for Scope of Treatment (MOST) in place and did not wish to discuss them further at that	F 657	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 73 Code status was updated on the care plan on 07/11/23 by the Case Mix Director. Resident # 76 code status and diet order was updated on the care plan on 07/11/23 by the Case Mix Director. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Medical Record Coordinator conducted a 100% review of all residents code status compared to their Care Plan. 3 of 90 Residents required revision of	

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F 657	Continued From page 20 time. No advanced directive was found in Resident #73's medical record. A current active physician's order for Resident #73 dated 12/15/22 was for code status: full code (attempt resuscitation). A review of his quarterly Minimum Data set (MDS) assessment dated 4/18/23 revealed he was severely cognitively impaired. A review of his current comprehensive care plan revealed his last care conference date was 5/31/23. The problem area of advanced directives, initiated on 12/15/22 and last edited on 4/26/23, indicated to attempt resuscitation. The short-term goal with a target date of 7/18/23 for this problem area indicated if Resident #73's heart stopped, or he stopped breathing cardio-pulmonary resuscitation (CPR) would not be initiated in honor of Resident #73's DNR wishes through the next review period. On 7/11/23 at 3:22 PM an interview with the Social Worker (SW) indicated she attended Resident #73's care conference on 5/31/23. She stated his advanced directives were discussed. She went on to say Resident #73's code status was full code. She further indicated she would have been responsible for ensuring the accuracy of the advanced directives problem and short-term goal on his current comprehensive care plan. She stated the short-term goal information indicating if Resident #73's heart stopped, or he stopped breathing cardio-pulmonary resuscitation (CPR) would not be initiated in honor of Resident #73's DNR	F 657	their care plans for code status. The Case Mix Director completed a 100% review of residents current diet orders versus Resident Nutritional Care plans, 45 of 90 residents reviewed required revisions to their care plans. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/03/23 The Interdisciplinary Team was educated by the Case Mix Director regarding accuracy of resident care plans related to code status and nutritional status. Members of the Interdisciplinary Team (Nurse Management, Social Worker, Activity Director, Certified Dietary Manager) who have not been educated by 8/4/2023 will be educated prior to their next scheduled shift or removed from the schedule. This education has been added to the general orientation on any newly hired Interdisciplinary Team member. The Medical Records Coordinator is reviewing Resident code status monthly and comparing it to the Residents care plan to validate consistency throughout the electronic health record. The Certified Dietary Manager is reviewing the Nutritional Care plans to validate their current dietary order and preferences are identified. This review will occur monthly for current residents and weekly for four weeks for newly admitted	

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F 657	Continued From page 21 wishes through the next review period was not accurate and she should have corrected it. She stated this was an oversight. On 7/13/23 at 10:58 AM an interview with the Director of Nursing (DON) indicated residents' care plans should be an accurate reflection of a residents' current orders and status. 2. Resident #76 was admitted to the facility on 2/6/23 with a diagnosis of stroke. A review of Resident #73's medical record revealed a Do Not Resuscitate (DNR) form with an effective date of 3/29/23 with a check in the box marked no expiration signed by her medical provider. It further revealed active physician's orders of code status: DNR dated 3/8/23 and diet: mechanical soft with regular liquids. A review of her quarterly Minimum Data set (MDS) assessment dated 5/8/23 revealed she was severely cognitively impaired. A review of Resident #73's current comprehensive care plan revealed her last care conference date was 6/29/23. The problem area of advanced directives, initiated on 2/7/23 and last edited on 3/12/23, indicated to attempt resuscitation. The short-term goal with a target date of 6/30/23 for this problem area indicated Resident #73's advanced directives were in effect, and her wishes and directions would be carried out in accordance with her advance directives on an ongoing basis. An additional problem area of nutritional status, initiated on 2/11/23 and last edited on 5/4/23, revealed an approach with a start date of 2/11/23 of mechanically altered diet pureed with nectar	F 657	residents. The MDS (Interdisciplinary Team) will review ten care plans weekly for four weeks, then five care plans weekly for four weeks, five care plans monthly for accuracy and consistency of code status and dietary requirements, with the Residents MDS. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Certified Dietary Manager will present the analysis of the care plan audits to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. Include dates when corrective action will be completed. August 8, 2023	

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	345357	A. BUILDING _____ B. WING _____	C 07/13/2023

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F 657	Continued From page 22 thickened liquids. On 7/11/23 at 3:22 PM an interview with the Social Worker (SW) indicated she attended Resident #76's care conference on 6/29/23. She stated her advanced directives were discussed. She went on to say Resident #76's code status was DNR. She further indicated she would have been responsible for ensuring the accuracy of the advanced directives problem and short-term goal on her care plan. She stated the advanced directives problem area indicating to attempt resuscitation was not accurate and she should have corrected it. She stated this was an oversight. On 7/12/23 at 10:33 AM an interview with the Dietary Manager (DM) indicated he could not recall if he had been present at Resident #76's 6/29/23 care conference but if he could not attend a resident's care conference, he would let another member of the team know. He stated he would provide any pertinent information to that team member to bring to the care conference and would receive the update from that team member after the meeting. He stated he would have been responsible for updating and ensuring the accuracy of the nutritional status problem area and approaches on Resident #76's current comprehensive care plan. He stated it must have just slipped his mind. On 7/13/23 at 10:58 AM an interview with the Director of Nursing (DON) indicated residents' care plans should be an accurate reflection of a residents' current orders and status.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/8/23

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F 677	Continued From page 23 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide nail care for 1 of 8 residents (Resident #73) reviewed who were dependent on facility staff for activities of daily living (ADL) care. Findings included: Resident #73 was admitted to the facility on 12/15/22 with diagnoses including stroke and diabetes mellitus (DM). A review of his quarterly Minimum Data set (MDS) assessment dated 4/18/23 revealed he was severely cognitively impaired. He had no behaviors or rejection of care. He required the total assistance of 1 person for personal hygiene and bathing. He had functional limitation of range of motion of his upper extremities on one side. A review of the current comprehensive care plan for Resident #73 revealed a problem area initiated on 12/15/22 last edited on 4/26/23 of at risk for ADL decline. The goal was for Resident #73 to have his ADL needs met through the next review. An intervention was to provide assistance as needed. On 7/10/23 at 10:14 AM an observation of Resident #73 revealed the fingernails of his right hand appeared long, extending past his fingertip and curving downward touching his palm. The	F 677	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The skin integrity nurse completed nail care on 07/13/23 for resident # 73 "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Health Services, Nurse Managers and Licensed Nurses completed a review of all resident nails. 26 of 90 residents required nail care to be performed. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/02/23 the Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers began education on performing nail care with bathing and as needed to the Certified Nurse Aides. This educated included notification to the Licensed Nurse if the resident refused nailed care. This education will be completed by	

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F 677	Continued From page 24 fingernails of his left hand were observed to appear long extending past his fingertips with dark debris under the nails. The thumbnail of his left hand was jagged. On 7/11/23 at 1:41 PM an observation of Resident #73 revealed the condition of his fingernails remained unchanged. An interview with Resident #73 at that time indicated he felt his fingernails were too long and needed cutting. He stated he had asked to have his nails trimmed but was told they could not be. He further indicated he could not recall who or when he asked. On 7/12/23 at 1:42 PM an observation of Resident #73 revealed the condition of his fingernails remained unchanged. An interview with Resident #73 at that time indicated he had his bath that day. On 7/12/23 at 1:47 PM an interview with Nurse Aide (NA) #1 indicated she was caring for Resident #73 that day. She stated he had not refused any care. She went on to say she provided him with a complete bed bath which included washing his hands. She stated she had noticed his fingernails were long and needed trimming. She further indicated she had also noticed the fingernails of his left hand were dirty. NA #1 stated she had tried to clean his fingernails with a washcloth but had not been able to get the dirt out from under the nails with the washcloth. She went on to say providing nail care to residents included trimming the fingernails and using a wooden dowel to remove debris from under the nails. She further indicated she had not trimmed Resident #73's fingernails or used a dowel to get the debris from under his nails during his bed bath because she had not had the	F 677	8/4/2023, Certified Nurse Aides who have not been educated by 8/4/23 will be educated prior to their next scheduled shift or removed from the schedule until education is completed. The Nurse Managers (Director of Health Services, Clinical Competency Coordinator, Unit Managers, Nurse Navigator , etc.) are reviewing 20 resident nails weekly for four weeks the 20 residents monthly for four months, then 10 residents monthly thereafter, for clean manicured nails, and if resident has refused nail care documentation of refusal in the electronic health record. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing and/or Unit Manager will present the analysis of the nail care review to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan. "Include dates when corrective action will be completed. August 8, 2023	

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equipment with her at the time. She stated she meant to go back and do this but had not gotten a chance to.

On 7/12/23 at 2:16 PM an interview with NA #2 indicated she was assigned to care for Resident #73 on 7/11/23 from 7AM-3PM. She stated this was his shower day, but he had refused his shower, so she provided him with a complete bed bath instead. She went on to say she noticed his fingernails were long and needed trimming. She further indicated she told Resident #73 that his fingernails were so long that they were beginning to press into the palm of his hand, and she needed to trim them, but he had refused. NA #2 stated she had not gone back to attempt again, had not documented the refusal anywhere and had not reported Resident #73's long fingernails or his refusal to allow her to trim them to the nurse.

On 7/12/23 at 2:42 PM an interview with Nurse #2 indicated she was assigned to Resident #73 on 7/11/23 from 7AM-7PM. She stated the NAs were supposed to observe resident's fingernails during ADL care daily and cut or trim and clean them if they needed it. She stated she had not been notified that Resident #73 needed his fingernails cut, trimmed or cleaned and had refused or that the NA had not been able to do this.

On 7/12/23 at 4:02 PM an interview with NA #6 indicated she provided Resident #73 with a complete bed bath on 7/10/23. She stated she noticed his fingernails were long and needed trimming. She stated she had not done it because she had not had time. She went on to say sometimes the nurse would help with this. She further indicated she had not asked the nurse to

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help or notified her that Resident #73 needed his nails trimmed and she did not have time to do it.

On 7/12/23 at 4:15 PM an interview with Nurse #4 indicated she cared for Resident #73 on 7/10/23 from 7AM-7PM. She stated she was familiar with Resident #73 and had trimmed his nails in the past. She stated she had not been notified on 7/10/23 that Resident #73 needed his nails trimmed or she would have gladly done this.

On 7/13/23 at 10:17 AM an interview with the Treatment Nurse indicated she completed a full body skin assessment for Resident #73 on 7/9/23. She stated this would have included observing his hands. She went on to say she had noticed on 7/9/23 that Resident #73's fingernails were long and needed to be trimmed but she had not done this. She stated the NAs would usually do this during a resident's daily ADL care. She further indicated if the NAs could not or the resident refused, the NAs were to notify the nurse. She went on to say she had meant to go back and trim Resident #73's fingernails but had not gotten around to it.

On 7/12/23 at 2:02 PM an observation of Resident #73's fingernails was conducted with the Director of Nursing (DON). The DON used a measuring tape to determine the length of Resident #73's fingernails. She stated the fingernails of his right hand were 1 centimeter (cm) long and curved towards his palm. She stated there were no fingernail marks in Resident #73's right palm. She further indicated the fingernails of his left hand were ½ cm long with dark debris under the nails that looked like food. She went on to say his left thumbnail was broken and jagged. The DON stated NAs should be

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F 677	Continued From page 27 making observations of resident's fingernails during ADL care daily to ensure they were clean and cut or trimmed. She went on to say there was no reason the NAs could not clean and cut or trim Resident #73's fingernails. She further indicated based on the appearance of Resident #73's fingernails, this should have been done before now. The DON stated if the NA caring for Resident #73 had not been able to clean and cut or trim his fingernails for any reason, the NA should have notified his nurse. She stated any refusal of care should be documented. On 7/13/23 at 11:37 AM an interview with the Administrator indicated NAs should be performing observations of residents fingernails during daily ADL care. She stated the NAs would be responsible for cleaning and trimming or cutting a resident's fingernails if this was needed. She went on to say if for any reason the NA observed a resident's fingernails needed cleaning and trimming or cutting and couldn't do it, the NA should be reporting it to the nurse.	F 677		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		8/8/23

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professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 29 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to have a complete and accurate medical record related to documentation of a resident assessment following a fall. This occurred for 1 of 1 resident (Resident #31) reviewed for accidents. Findings included: Resident #31 was admitted to the facility on 7-30-21 with multiple diagnoses that included absence of left leg below the knee. The significant change Minimum Data Set (MDS) dated 5-18-23 revealed Resident #31 was moderately cognitively impaired and required two people to assist with transfers. Resident #31's care plan dated 5-20-23 revealed Resident #31 was at risk for falls related to a left below the knee amputation. The goal for Resident #31 was not to sustain an injury related to falling. The interventions for the goal were encourage resident to ring for assistance, assist with toileting	F 842	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Documentation regarding the event of 5/20/2023 for Resident # 31 has been uploaded into the electronic health record. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by an incomplete electronic health record. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/01//23 the Director of Health Services, Clinical Competency	

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F 842	Continued From page 30 and transfers, cue for safety awareness, keep environment safe, and place call light within reach. Review of the facility's "Facility Event Investigation Form" dated 5-20-23 written by Nurse #3 revealed documentation that Resident #31 was found sitting on the edge of her wheelchair with her buttocks nearly on the floor. The nurse documented she had lowered Resident #31 to the floor and once assistance was obtained; Resident #31 was placed in the bed. The document does not include any assessment information. Nurse #3's nursing note dated 5-20-23 at 2:35am revealed Resident #31 was found at 2:00am on the edge of her wheelchair and her buttocks nearly on the floor. The nurse documented she attempted to support Resident #31, but the resident's body slid down, so she slowly placed Resident #3 on the floor. Nurse #3 documented there was no head trauma, and the Physician and resident representative was notified. The documentation did not include any other assessment of the resident. Resident #31 was interviewed on 7-10-23 at 12:08pm. The resident discussed falling in May 2023 or June 2023 in the "middle" of the night. She stated she was able to reach her call light but had to wait an hour for someone to come and help her. She explained she knew it was an hour because of the clock on her wall. Resident #31 stated Nurse #3 came into her room but was unable to assist her back into bed. The resident stated Nurse #3 woke up her roommate to go find a Nursing Assistant (NA) to help place her back into bed. She explained the roommate could not	F 842	Coordinator and/or Nurse Managers began education to the Licensed Nurses regarding the importance of an accurate medical record, with focus on event documentation (event report, SBAR, skin observation). Licensed Nurses not educated by 8/4/2023 will be educated prior to their next scheduled shift or removed from the schedule. This education has been added to the general orientation for all newly hired Licensed Nurses upon hire. The Director of Health Services and/or Nurse Managers will review the facility 24-hour report for events and ensure the electronic medical record is accurate for the event including (event report, SBAR, skin observation). This review will occur daily for five days, weekly for four weeks then monthly thereafter. Discrepancies in the electronic health record will be corrected when identified to maintain an accurate record. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing will present the analysis of the event / electronic medical record accuracy review to the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed. The Quality Assurance Committee will determine the need for continued monitoring or adjustment to the plan.	

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find anyone, so Nurse #3 left her on the floor to go find some help. She stated she lay on the floor for an hour before (Nursing Assistant) NA #5 came into her room with Nurse #3 and said they picked her up and laid her in the bed. Resident #31 stated she could not remember if Nurse #3 had completed an assessment.

The Director of Nursing (DON) was interviewed on 7-12-23 at 10:17am. The DON discussed not knowing if vital signs or an assessment of Resident #31 had been completed after her fall on 5-20-23. The DON stated there was no documentation of an assessment or vital signs being completed.

Nurse #3 was interviewed by telephone on 7-12-23 at 3:04pm. Nurse #3 confirmed she was the nurse for Resident #31 on 5-20-23 during the 11:00pm to 7:00am shift. She stated she had answered Resident #31's call light and when she walked into Resident #31's room, she saw the resident sitting on the edge of her wheelchair with her buttocks almost touching the floor. Nurse #3 stated she was the only employee in the room and was unable to get the resident back into her chair, so she lowered the resident onto the floor. The nurse stated Resident #31's call light was still on, but no one was coming to help her, so she asked the resident's roommate to go out in the hall and get some help. She stated she did not know how long the resident's call light had been on prior to her coming to Resident #31's room and did not know how long it took for another employee to come help her with the resident but stated "it was a while, but I don't think it was quite an hour." Nurse #3 explained the resident's roommate was unable to locate anyone to help, so she left the resident safely on the floor and

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retrieved assistance from NA #5 to place the resident back in bed. The nurse stated she had assessed Resident #31 once she was back in bed and performed vital signs. She stated this would have been documented in her progress notes and did not know why there was not any documentation of her assessment or vital signs.

During a telephone interview with NA #5 on 7-13-23 at 8:27am, the NA confirmed he had worked 11:00m to 7:00am on 5-20-23. He stated he was not assigned to Resident #31 but had been asked by Nurse #3 to assist in placing the resident back in bed. NA #5 stated when he walked in the resident's room, the resident was on the floor next to her bed. He stated he did not know what happened or how long the resident had been on the floor, but he stated he picked the resident up and placed her back into bed. The NA stated once Resident #31 was back in bed he saw Nurse #3 start taking the resident's vital signs and performing an assessment.

The DON was interviewed on 7-13-23 at 10:12am. The DON explained when a resident fell, the nurse would complete a full assessment to include vital signs, body assessment to check for injury, notify the resident representative and Physician. She stated the nurse should document in the nursing notes, change in condition form, and risk management form. The DON discussed the nurse had not completed a change in condition form and an assessment with vital signs and body assessment was not completed after Resident #31's fall. She stated she expected staff to fill out all required documentation and complete a full assessment.

During an interview with the Administrator on

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F 842	Continued From page 33 7-13-23 at 12:17pm, the Administrator discussed staff needed to take care of the resident that fell first and make sure they are safe and then complete the necessary documentation. The Administrator discussed Nurse #3 was a new nurse and was unaware of what documentation needed to be completed after Resident #31's fall. She stated she expected all staff to document what they had done after the fall to include assessments with vital signs.	F 842		
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.	F 867		8/8/23

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

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

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 36 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Nurse Practitioner (NP), and Medical Doctor (MD) interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 4/21/22 recertification/complaint survey and the 10/4/21 and 2/9/21 focused infection control and complaint investigation surveys. This was for was for 2 deficiencies in the areas of F550 Dignity and F677 Activities of Daily Living (ADL) that were cited on the 4/21/22 recertification and complaint investigation survey, 1 deficiency in the area of F607 Developing and Implementing Abuse Policies that was cited on the 10/4/21 focused infection control and complaint investigation and 1 deficiency in the area of F641 Accuracy of Assessments that was cited on the 2/9/21 focused infection control and complaint investigation. These 4 deficiencies were cited again on the current recertification survey of 7/13/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to:	F 867	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 08/03/23, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT) to discuss the 4 repeat tags, F 550, F 607, F 677 and F 641. A root cause analysis identified that the facility has gone through increased turnover in leadership, extended vacancies in key managing/monitoring positions and partner ownership in these identified areas. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. On 07/13/23 the Administrator reviewed surveys for 2/9/2021, 10/4/2021 and 4/21/2022 to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI meetings.	

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F 867	Continued From page 37 F550: Based on record review, resident, and staff interviews, the facility failed to maintain a resident's dignity by not answering a call light and allowing the resident to sit on the floor for an extended period causing Resident #31 to feel "afraid", "neglected", shaky, and upset. This occurred for 1 of 8 residents reviewed for dignity (Resident #31). During the recertification/complaint survey of 4/21/22 the facility was cited for failing provide incontinence care. F607: Based on record review, resident, and staff interviews, the facility failed to implement their abuse policy and procedure in reporting when Nursing Assistant (NA) #8, NA #9, and NA #10 did not immediately report an allegation of abuse between a staff (NA #7) member and a resident (Resident #8) resulting in a lack of protection for Resident #8 and other facility residents. The facility also failed to report to the state agency within the required two-hour time frame. This occurred for 1 of 1 resident (Resident #8) reviewed for abuse. During the 10/4/21 focused infection control and complaint investigation the facility was cited for failing to implement the neglect policy and thoroughly investigate a neglect allegation. F641: Based on record review and staff interviews the facility failed to accurately code anticoagulant medication use on a Minimum Data Set (MDS) assessment for 2 of 6 residents reviewed for unnecessary medications (Resident #48 and Resident #44).	F 867	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/03/23 the Administrator educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys. CASPER reports were distributed for on-going reference. The Administrator and Facility Management Team will complete the On-line educational course Implementing Quality Assurance Performance Improvement in the Nursing Facilities via the Relias training site by 8/4/2023. Managers that have not completed the training by 8/4/2023 will be removed from the schedule until training is completed. This education has been added to the general orientation of all newly hired Facility Managers during general orientation. The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Citations F 550, F607, F 677 and F 641. monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly to review the tracking and trending	

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F 867	Continued From page 38 During the 2/9/21 focused infection control and complaint investigation the facility was cited for failing to accurately code the MDS in the area of immunizations. F677: Based on observations, record review and resident and staff interviews the facility failed to provide nail care for 1 of 8 residents (Resident #73) reviewed who were dependent on facility staff for activities of daily living (ADL) care. During the recertification/complaint survey of 4/21/22 the facility was cited for failing provide incontinence care. On 7/13/23 at 1:13 PM an interview with the Administrator indicated she could not say for sure what the root cause was regarding the things that happened prior to her coming to the facility in June 2022. She stated for ADL care, she felt this was a misunderstanding among staff regarding the residents care refusals. She went on to say she felt this was an isolated issue. She further indicated since she started at the facility, one of the biggest things they had been working on in Quality Assurance and Performance Improvement (QAPI) was response time for call bells. The Administrator spoke about the deficient practice at F550 and stated the facility implemented a walkie talkie system and staff were to carry these on their person. She went on to say she felt that if the nurse was carrying her walkie talkie like she should have been when the fall occurred, the delay in response to the call would not have occurred.	F 867	analysis of areas that led to the repeat tag/deficiency. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Administrator will lead Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have led to repeated deficiency (F550, F 677, F 607 and F 641). This will ensure the facility is identifying areas of non-compliance and addressing them as needed to prevent further deficient practice related to significant change assessments. A member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or Area Vice President will attend QAPI meetings for the next 3 months and then quarterly for 3 quarters to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly and/or as needed for 3 quarters for further recommendations until compliance is sustained. Include dates when corrective action will be completed. August 8, 2023	