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	345370	A. BUILDING _____ B. WING _____	C 09/13/2023

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 09/11/2023 through 09/13/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# FWFN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 9/11/23 through 9/13/23. Event ID# FWFN11. The following intakes were investigated: NC00205838, NC000202314, NC000200000545, NC000200355 and NC000200288. One of the 20 complaint allegations resulted in a deficiency at F689.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of pain assessment for 1 of 1 (Resident #28) resident reviewed for pain. The findings included: Resident #28 was admitted to the facility on 11/7/2016. Resident #28's active physician orders included the following;	F 641	To remain in compliance with all federal and state regulations the facility has taken the actions set forth in this plan. Resident #28 Minimum data set quarterly assessment with Assessment Reference date of 8/20/2023 reviewed and resident does not have pain interview coded on the Minimum data set assessment. Resident noted with no pain interview completed in the assessment reference date observation period. Item J0200 must be coded 1, Yes, and the	9/29/23

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

Electronically Signed | 10/02/2023

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F 641	Continued From page 1 Complete pain assessment every shift. Ask the resident if they are in pain according to a 1-10 scale. Document response. The order had a start date of 3/8/2023. Give Oxycodone-Acetaminophen Tablet 10-325 milligram (MG). Give 1 tablet by mouth every 6 hours for pain. The order had a start date of 3/8/2023. Give Gabapentin, 100 MG, 2 capsules by mouth three times a day for chronic pain. The order had a start date of 3/8/2023. The Resident's medical record revealed a progress note by the provider dated 8/18/2023 indicating the resident continued to have concerns regarding uncontrolled pain and would be referred to local pain clinic. The resident's quarterly Minimum Data Set (MDS) dated 8/20/2023 indicated the resident received opioid medication 7 out of 7 days during the assessment period. The MDS was coded "no" for staff assessment of pain. Additionally, the areas of pain frequency, presence of pain, intensity of pain, and effects on function were not assessed. On 9/12/2023 at 2:00 PM an interview was conducted with the MDS nurse. She reviewed Resident #28's quarterly MDS dated 8/20/2023 and stated she did not know why pain was not assessed. She stated she was on vacation during his assessment period and section J was completed by a MDS nurse from corporate (floater). She stated she did not review the section before she locked and transmitted the	F 641	standard no information code (a dash -) entered in the resident interview items J0300□J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No. Assessment correction completed on 9/27/2023 for item J0200 Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of the current residents□ most recent Minimum data set assessments that have been accepted in IQIES in the past 30 days will be completed in order to identify assessments coded as not assessed for pain interview items J0200-J0600. For those assessments identified during audit, pain interview items J0200-J0600 will be reviewed to determine if it was coded accurately on the Minimum data set assessment. This audit will be completed by regional RAI consultant no later than ¿¿9/27/2023. Any assessment identified as having inaccurate coding of J0200-J0600 will have a correction of that assessment completed. Any necessary Minimum data set corrections identified from the audit will be completed no later than 9/27/2023. Systemic Changes By 9/27/2023 the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse and the floater staff that includes the importance that the assessment is	

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F 641	Continued From page 2 MDS. The section for pain should have been assessed and completed.	F 641	coded accurately. Special emphasis will be placed on the following area of the Minimum Data Set assessment: J0200: Should Pain Assessment Interview Be Conducted? Coding Instructions " Code 0, no: if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800). " Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300). Coding Tips and Special Populations " Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. " If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard no information code (a dash -) entered in the resident interview items J0300□J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No. The MDS needs to be thoroughly reviewed for accuracy prior to saving and	

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F 641	Continued From page 3	F 641	signing the pain interview section of the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for item J0200-J0600 of the pain interview to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled Accurate Coding of MDS Audit Tool. Reports will be presented to the weekly Quality Assurance committee by the NHA or DON to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Date of Compliance: 9/29/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		9/29/23

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F 656	Continued From page 4	F 656		

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

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F 656	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to develop an individualized and comprehensive care plan for contracture management (Resident #15) and skin impairment (Resident #1). This was for 2 of 19 residents reviewed. The findings included: 1) Resident #15 was admitted to the facility on 10/7/21 with diagnoses that included a history of traumatic brain injury and muscle spasms. An Occupational Therapy (OT) Evaluation and Plan of Treatment dated 2/3/23 indicated that Resident #15 was being seen due to progressive contracture of the left hand and fingers. She had flexion contractures present to the second to fifth fingers on the left hand. A quarterly Minimum Data Set (MDS) assessment dated 8/7/23 indicated Resident #15 was cognitively with limited range of motion present to her bilateral lower extremities. A review of the September 2023 active physician orders included an order to place resting hand splint to the left hand for four hours as tolerated every day. Resident #15's active care plan, last reviewed 7/17/23, was reviewed and revealed there was no care plan developed to address the left-hand finger contracture or use of the left-hand splint. An observation and interview occurred on 9/11/23 at 2:30 PM of Resident #15, who was lying in	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective action Resident #15: Review of resident□s care plan last reviewed on 7/17/2023 did not include resting hand splint to left hand. Care plan has been reviewed and revised on 9/14/2023 by facility Minimum data set nurse. Resident has a comprehensive care plan that includes resting hand splint to left hand. Resident #1: Review of resident□s care plan last reviewed on 7/17/2023 did not include non-pressure wound to left lateral neck. Care plan reviewed and revised on 9/13/2023 by facility minimum data set nurse. Resident has a comprehensive care plan that includes non-pressure wound to left lateral neck Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents who use splints have the potential to be affected by the alleged practice. By 9/27/2023 an audit will be completed by Director of nursing or nurse support staff to review all current residents for use of splints. All current residents with splints will have a review of care plan to verify splint usage is on the plan of care with revision of plan of care to accurately reflect splint usage	

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F 656	Continued From page 6 bed. She stated she wore a splint to the left hand on most days for about two to four hours. She was noted with flexion contractures to the second to fifth fingers and had difficulty grasping objects with her left hand. On 9/13/23 at 12:00 PM, an interview occurred with the MDS Nurse, who reviewed Resident #15's active care plan. She confirmed a care plan was not present for the left-hand finger contractures or use of the left-hand splint but should have been developed. She felt it was an oversight. The Administrator was interviewed on 9/13/23 at 3:57 PM, and stated it was her expectation for the care plan to be person centered and should have included Resident #15's left finger contractures and use of the hand splint. 2. Resident #1 was admitted to the facility on 06/14/12 with diagnoses that included a history of persistent vegetative state, traumatic brain injury, and moderate protein-calorie malnutrition. A quarterly Minimum Data Set (MDS) assessment dated 06/17/23 indicated Resident #1 was in a persistent vegetative state with limited range of motion present to her bilateral lower and lower extremities. A review of the September 2023 active physician orders included an order to cleanse left lateral neck wound with normal saline, apply collagen sheet with silver (collagen gel wound dressing with silver oxide), hydrofera blue (manages absorption of secretions in the wound) and cover with a super absorbent dressing. Change every 2 days on day shift.	F 656	as applicable. This will be completed by 9/28/2023 By 9/28/2023 an audit will be completed by the-Director of nursing or nurse support staff to review all current residents for non-pressure wounds. All current residents with non-pressure wounds, will have a review of current care plan to verify non-pressure wound/skin injury is on the plan of care with revision of plan of care to accurately reflect identified non-pressure skin conditions as applicable. This will be completed by 9/29/2023. Systemic Changes: On 9/26/2023, the regional RAI consultant did an in-service with the facility Minimum Data Set (MDS) Coordinator and floaters that work remotely. The education focused on: the purpose of a care plan, when care plans should be initiated or updated, understanding the care plan revisions are on- going. The care plan must be oriented toward preventing avoidable declines in functioning or functional status, managing risk factors, and evaluating treatments objectives and outcomes of care. A well developed and executed care plan looks at each resident as a whole human being. The development and implementing a comprehensive person-centered care plan for each resident, consistent with the resident□s current status and needs to include impaired mobility with splint usage	

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F 656	Continued From page 7 Resident #1's active care plan, last reviewed 7/02/23, was reviewed and revealed there was no care plan developed to address the wound to Resident #1 ' s neck. An observation of wound care was completed on 09/13/23 at 11:02 AM with the Wound Physician. Resident #1 was observed to have a wound to the left lateral neck approximately quarter sized. The area was cleaned, measured and a dressing was applied. On 9/13/23 at 2:40 PM, an interview occurred with the MDS Nurse, who reviewed Resident #1's active care plan. She confirmed a care plan was not present for the non-pressure wound to Resident #1 ' s left lateral neck and she stated she thought she had added the wound to the active care plan. She felt it was an oversight. The Administrator was interviewed on 9/13/23 at 3:57 PM and stated the care plan should be person centered and should have included the non-pressure wound to Resident #1 ' s neck.	F 656	and impaired skin integrity. This information has been integrated into the standard orientation training for employees participating in care planning process. Monitoring Procedure to ensure the plan of corrections is effective and that the specific deficiency cited remains corrected and/in compliance with regulatory requirements. To ensure compliance, The Director of Nursing and/or designee will observe 5 residents to evaluate splint usage and non-pressure wounds are care planned if applicable, evaluate interventions that are care planned, and ensure interventions are in place. Specifically, the Development of Comprehensive Care Plan Audit Tool will be used to determine if randomly selected residents are care planned for splint usage and non-pressure wounds with related goals and interventions. This will be done on weekly basis for 4 weeks then monthly for months using the audit tool titled Development of Comprehensive Care Plan Audit. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to	

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F 656	Continued From page 8	F 656	the Nursing Home Administrator/DON for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality Assurance Meeting. Weekly QA Committee meeting is attended by Administrator Director of Nursing, ADON/SDC, MDS Coordinator, Unit Manager, Support Nurse, Therapy Director, HIM (Health Information Management), Dietary Manager, Wound Nurse, Social Worker. Date of Compliance: 9/29/2023	
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 record reviews, observations, staff and resident interviews, the facility failed to ensure fall mats were in place as ordered (Resident #83) and failed to store smoking supplies in a safe manner (Resident #58). This was for 2 of 7 residents reviewed for accidents. The findings included: 1) Resident #83 was admitted to the facility on 5/31/23 with diagnoses that included dementia	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	9/29/23

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F 689	Continued From page 9 and a stroke with ataxia (limited muscle control in extremities). A record review revealed Resident #83 had the following falls by his bed: " On 5/31/23 was found between the wheelchair and his bed on the floor. " On 6/4/23 was found on the floor by his bed. " On 6/7/23 was found lying on the floor of his room. " On 6/15/23 was found sitting beside his bed. " On 6/25/23 was found at the foot of his bed on the floor. A quarterly Minimum Data Set (MDS) assessment dated 8/18/23 indicated Resident #83 had severe cognitive impairment and required limited to extensive assistance for Activities of Daily Living (ADLs). A wheelchair was used for mobility, and he was coded with 2 or more falls with no injury and 1 fall with minor injury since the last assessment. A record review revealed Resident #83 was observed lying on the floor by the bed on 8/29/23. A review of the September 2023 active physician orders included an order dated 8/31/23 for nursing to place fall mat beside patient's bed due to recent falls. Resident #83's active care plan, last reviewed 9/6/23, included a focus area for having had an actual fall with risk for further due to poor balance and unsteady gait. The interventions included fall mat at bedside while in bed that was initiated on 8/31/23. A record review revealed Resident #83 was noted	F 689	deficiencies cited have been or will be corrected by the dates indicated. Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Corrective Actions taken for the resident affected by the deficient practice: Resident #83 was reassessed for the use of fall mats as an intervention for frequent falls. Resident's care plan was updated. Corrective action for those residents affected by the alleged deficient practice: All current residents who use fall mats have the potential to be affected by the alleged practice. The Administrator, Director of Nursing, or nurse support staff will initiate an audit tool for Residents with Fall Mats. This audit tool will check to ensure all residents with fall mats have an order, the fall mats are care planned as an appropriate intervention, if the resident had a room change, and if the fall mat was moved with the resident. On 9-25-23 the Nursing Home Administrator (NHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) audited all current residents with fall mats. The initial audit identified one resident that was not care planned for fall mats but had fall mats as an intervention the in place. This resident did have an assessment and order for fall mats. The deficient practice was resolved. No other resident was identified as being affected by this deficient practice.	

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F 689	Continued From page 10 on the floor beside his bed on 9/6/23. On 9/7/23 Resident #83 was moved to the 400 hall for increased visibility for safety. An observation occurred of Resident #83's bed on 9/11/23 at 11:20 AM. The bed was in the lowest position with a concave mattress present. There were no fall mats located in the room or bathroom. On 9/11/23 at 12:18 PM, Resident #83 was observed lying in bed. There was no fall mat to the bedside nor in the room or bathroom. Nurse Aide (NA) #4 was interviewed on 9/11/23 at 12:30 PM, who was assigned to Resident #83. She indicated staff monitor for safety as Resident #83 will try to transfer from the bed to the wheelchair on his own, as well as keeping the bed in the lowest position. When asked about fall mats, she stated she was unsure and had not seen any fall mats being used for Resident #83. On 9/12/23 at 10:12 AM, an observation was made of Resident #83 lying in bed. There was no fall mat present to the side of the bed, in the room or the bathroom. An observation was made of Resident #83 on 9/13/23 at 9:20 AM while he was lying in bed. There was no fall mat present to the side of the bed, in the room or bathroom. An interview occurred with Certified Medical Assistant (CMA) #1 on 9/13/23 at 12:06 PM, who was assigned to Resident #83. She was unsure if a fall mat was being used currently but recalled seeing one when Resident #83 was in a different	F 689	Measures/Systemic Changes to prevent reoccurrence and remain corrected and/or compliance with the regulation: Administrator, DON, Staff Development Clinicia (SDC), or designee in-serviced all staff including agency on Fall Prevention and Post Fall Care. This education highlighted that fall interventions must be maintained when moving a resident, if a resident has fall mats and his or her room assignment changes the housekeepers must move fall mats to the new room. It further educates that the nurse aides are responsible for inspecting the room and ensuring the interventions are in place. All staff including agency were required to complete education by 9/28. Any staff member that did not complete the education by 9/28 is ineligible to work until the education is completed. The Director of Nursing or designee will use the Quality Assurance Monitoring tool to audit all residents with room changes to ensure if they have fall mats, the fall mats are moved to the new room with them. The Quality Assurance (QA) Monitoring Tool Fall Mats will be completed weekly for 4 weeks and monthly for three months to ensure all residents that have a room change has their fall mats in place in the new room. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini	

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F 689	Continued From page 11 room. The interim Director of Nursing (DON) was interviewed on 9/13/23 at 12:11 PM and stated that Resident #83 was recently moved to the 400 hall as it was a high traffic area and greater visibility for safety. She stated the fall mats were to be discontinued at that time and felt it was an oversight. On 9/13/23 at 3:57 PM, the Administrator was interviewed and stated it was her expectation for the fall mat to be in place if the order was present. 2.Resident #58 was admitted to the facility 7/24/2020. The resident's annual Minimum Data Set (MDS) dated 6/6/2023 indicated the resident had mild cognitive impairment. The facility provided a paper copy of the Smoking Policy, last revised 1/2023. The policy read in part: "Resdients that have been assessed by the interdisciplinary care team as cognitively intact and safe may keep cigarettes and lighters in a locked box in their room. The box must be locked at all times and must not be accessivle to confused residents". The resident's medical record included a smoking assessment was completed 7/6/2023. Resident was evaluated and deemed a safe smoker. The resident's comprehensive care plan was last updated on 7/6/2023 and included a focus for risk of injury related to his preference to smoke. The interventions included storing smoking items (cigarettes, pipes, lighters) in secure locations	F 689	Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Nursing Home Administrator/Director of Nursing for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality Assurance Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, Assistant Director Of Nursing/Staff Development Coordinator, MDS Coordinator, Unit Manager, Support Nurse, Therapy Director, HIM (Health Information Management), Dietary Manager, Wound Nurse, Social Worker. Date of Compliance: 9/29/2023 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Corrective Actions taken for the resident	

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F 689	Continued From page 12 such as nursing stations, medication carts, or locked in room). The intervention was dated 7/6/2023. On 9/12/2023 at 10:10 AM Resident#59 was observed in his room with 7 lighters and one partial pack of cigarettes on his bedside table. When asked about a lock box, he stated he did not have one. On 9/12/2023 at 10:15 AM writer entered Resident #58's room with the Director of Nursing (DON). The DON asked Resident #58 where his lock box was. He did not answer. The DON looked in the resident's drawers and his closet but did not find a lock box. The DON stated per policy, smoking supplies were to be secured at the nurse station, in the medication cart, or in a lock box in their room. She did not know why the resident did not have a lock box. Nurse Assistant (NA)#6 was interviewed 9/12/2023 at 10:30AM. She stated she had been in Resident #58's room several times that morning and had not noticed the smoking supplies on his bedside table. She further stated the resident was mostly independent and was a "safe smoker" so she did not spend a lot of time in his room. On 9/13/23 at 3:57 PM the Administrator was interviewed. She stated they have completed regular auditing of smoking supplies at least weekly. The audit was completed by the DON and included checking each resident who smoked for safe storage of smoking supplies. She further stated Resident #58 has a history of borrowing lighters from other residents and not returning them. She did not believe the lighters	F 689	affected by the deficient practice: On 9/25/2023 the Nursing Home Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON) used a QA tool resident focused rounds to evaluate each identified smoking resident□s room to assure smoking paraphernalia is secured safely. This audit tool will be done weekly for four weeks, then monthly for three months or until resolved. Results will be reported to the Quality Assurance (QA) Committee. Initial audits revealed two residents that did not have safe storage methods. The audit tool revealed that even though there was a signed smoking agreement with all residents desiring to smoke, several were not following the facility smoking rules for sharing paraphernalia and safe storage consistently. All independent smoking residents have items safely stored in lock boxes or in a nursing cart. Corrective action took place immediately for Resident #58 to ensure he was free from accidents. All lighters and smoking paraphernalia was removed from his room, with his permission, and locked in the nursing cart until a lock box was assigned to him. A lock box was given to this resident and deficient practice is resolves. On 9/18 all identified smokers were re-educated by the Staff Development Clinician on the facility smoking policy to include: proper storage of lighters and smoke paraphernalia. On 9/25/2023 the DON/ MDS	

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F 689	Continued From page 13 were functional. It was her expectation that smoking supplies be kept secure.	F 689	Nurse/ADON performed audits of residents identified as smokers for smoking UDAs and care plan accuracy to reflect smoking status. All residents identified as smokers were reeducated on facility smoking guidelines. All residents that smoke resigned the facility smoking agreement and it was uploaded into PCC. On 9/25/2023 the NHA/DON/ADON in-serviced all staff, including agency, on the facility smoking policy. All staff members must be educated on the smoking policy by 9/28/2023 to be eligible to work. Additionally, Resident Focused Room Rounds done by the interdisciplinary team daily will include the names of all smokers and will be checked for 30 days. On 9/26/2023, the regional RAI consultant did an inservice with the facility Minimum Data Set (MDS) Coordinator. The education focused on: development and implementing a comprehensive person-centered care plan for each resident, consistent with the resident□s current status and needs to include accurate fall interventions. This will be done on weekly basis for 4 weeks then monthly for 2 months using the audit tool titled Development of Comprehensive Care Plan Audit. The results of this audit will be reviewed at the	

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F 689	Continued From page 14	F 689	weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 9/29/2023	
F 761 SS=E	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	F 761		9/29/23

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F 761	Continued From page 15 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to date multi-use medications upon opening in 1 of 1 medication storage room and on 2 of 2 medication carts (100 hall and 200 hall medication carts) reviewed. Findings included: A. An observation was conducted on 09/13/23 at 9:28 AM of the East Wing medication storage room in the presence of Nurse #1. The observation revealed one multi use vial of Tuberculin purified protein with no opened date on vial. The vial appeared to be about less than half full of solution and located in the refrigerator. Nurse #1 confirmed the medication did not have an open date and discarded the vial. B. An observation was conducted on 09/13/23 at 1:30 PM of the medication cart on 200 Hall in the presence of Nurse #3. The observation revealed no opened date on the following multi-dose medications: 1. One multi-dose package of Ipratropium Bromide and Albuterol Sulfate 0.5mg/3ml inhalation vials. 2. One multi-dose package of Levalbuterol	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: Current corrective action for residents affected was reviewed by the Director of Nursing, Assistant Director of Nursing, RN Unit Manager, LPN Support Nurse, and Administrator. Review of the corrective action did not require and revisions from the current corrective action plan listed below: listed: The DON and ADON ensured any medications that were not labeled, dated, or stored according to	

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F 761	Continued From page 16 Nebulizer Solution 1.25mg inhalation vials. 3. One multi-dose Advair HFA AER Inhaler. 4. One multi-dose Albuterol AER PFA inhaler. 5. One multi-dose 10ml bottle of Systane Balance 0.6% solution eye drops. 6. One multi-dose 10ml bottle of Bepreve DRO 1.5% solution eye drops. Nurse #3 confirmed the medications were not dated and she removed them from the medication cart and discarded them. She indicated nurses were to write the date on multi-dose medications upon opening and check dates prior to administration. She stated she had been off the last two days and did not realize they were not dated. C. An observation was conducted on 09/13/23 at 1:48 PM of the medication cart on 100 Hall in the presence of Nurse #2. The observation revealed no opened date on the following multi-dose medications: 1. Two multi-dose packages of Retasis Emu 0.05% eye drops. 2. One multi-dose package of Ipratropium Bromide and Albuterol Sulfate 0.5mg/3ml inhalation vials. 3. One multi-dose package of Albuterol Sulfate Nebulizer Treatment 2.5mg/3ml inhalation vials. 4. One multi-dose Symbicort AER 80-4.5 inhaler.	F 761	policy and acceptable professional principles were immediately corrected. All drugs and biologicals used in the facility were stored per state and federal laws in locked compartments, at proper temperature controls, and accessible to authorized personnel only. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 09-21-2023, the Director of Nursing, Assistant Director of Nursing/Staff Development Nurse, and the Unit Support Nurses audited all medication carts, treatment carts, and medication rooms two times weekly to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 9-21-2023, 9-26-2023, and 9-28-2023. No resident was found to be affected by the deficient practice. 3. Education: On 9-22-2023, the DON and SDC began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened	

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F 761	Continued From page 17 5. One multi-dose albuterol inhaler. 6. One multi-dose Advair HFA AER inhaler. Nurse #2 confirmed the medications were not dated and she removed them from the medication cart and discarded them. She indicated nurses were to write the date on multi-dose medications upon opening and check dates prior to administration. She stated she did not realize they were not dated. She also stated that the pharmacy consultant checked medication carts for expired and undated medications although she was unsure how often. An interview was conducted on 09/13/23 at 2:04 PM with the Director of Nursing (DON). She stated nurses were to date multi-dose medications upon opening and they should be checking for dates daily prior to administration. During an interview with the Administrator on 09/13/23 at 3:57 PM she stated the nursing staff were to label all multi-use medications upon opening and they should be checking for dates daily prior to administration. Pharmacy consultants checked medication carts and storage rooms every couple of months for expired and undated medications.	F 761	with date open as indicated. " Pharmacy recommended storage for selected items. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 09-28-2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the medication and treatment carts and the medication room is free of expired medications for. This monitoring will consist of monitoring each cart once weekly. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance	

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F 761	Continued From page 18	F 761	Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager and Social Services Coordinator. Date of Compliance: 9/29/2023	
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		9/29/23

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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 21 (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, resident and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following recertification surveys dated 5/26/22 and a complaint investigation dated 10/13/21 for two deficiencies in the area of accurate coding the Minimum Data Set (641), comprehensive care planning (656) and in supervision to prevent accidents (F689). The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This tag is cross referenced to: F641- Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of pain assessment for 1 of 1 (Resident #28) resident reviewed for pain. During the recertification survey dated 5/26/22 the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of bowel and bladder and medications. During the complaint investigation dated 10/13/21 the facility failed to accurately code the Minimum	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Facility failed to maintain implemented procedures and monitoring processes to ensure repeat citations regarding accidents and MDS accuracy, and developing and implementing a comprehensive care plan. Process that lead to the deficiency: Change in facility Nursing Administration during 2022 and staff illnesses contributed the failure in follow-up of the QAPI systems and processes. Systemic Changes: The Quality Assurance Performance Improvement Committee was re-educated on 9/25/2023 on the purpose and function	

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	345370	A. BUILDING _____ B. WING _____	C 09/13/2023

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F 867	Continued From page 22 Data Set (MDS) assessments in the area of falls for 2 of 3 sampled residents reviewed for accidents. F656-Based on record reviews, observations, resident and staff interviews, the facility failed to develop an individualized and comprehensive care plan for contracture management (Resident #15) and skin impairment (Resident #1). During the recertification survey dated 5/26/22, the facility failed to develop a comprehensive care plan for the use of an as needed psychotropic medication and the use of oxygen. residents reviewed. During the complaint investigation dated 10/13/21, the facility failed to implement the interventions for falls as care planned 2 of 3 sampled residents reviewed for falls. F689- Based on record reviews, observations, staff and resident interviews, the facility failed to ensure fall mats were in place as ordered (Resident #83) and failed to store smoking supplies in a safe manner (Resident #58). During the recertification survey dated 5/26/22 the facility failed to provide wound care in a safe manner that resulted in a resident fall with injury during wound care and sustained a distal femur fracture. In addition, the facility failed to complete an investigation of the fall. The facility also failed to lift a non-ambulatory resident with a mechanical sling lift according to the manufacturer instructions resulting in a distal femur fracture.	F 867	of the committee by the Administrator on 9/29/2023. The Committee consists of the Medical Director, Administrator, Director of Nursing, ADON/SDC, Wound Nurse/IP, Business of Manager, Activities Director, Health Information Manager, Dietary Manager, Social Worker, Rehab Director, Dietician, and Maintenance/EVS Director. On 9/25/2023 Interdisciplinary Quality Assurance Performance Improvement members were reeducated on our policy to maintain a robust and active QAPI program to promote safe quality of care for our residents. members will be in-serviced on facility procedure, reporting of concerns and trends identified through observations and audits, and action plans to be developed as indicated based on these findings. – Measure progress toward goals: Scope to include quality of care, quality of life, resident choice, and resident choice. Corrective Actions for Systemic Change: Daily stand up/stand down and daily clinical reviews. Implement weekly residents at risk meeting to include QA'ing resident falls, weights, wounds and changes in condition. Weekly Quality Assurance meetings and monthly QAPI focusing on systems and processes with goal of achieving safe and high-quality interventions. We will use data to monitor our performance. We will evaluate audit tools, Real Time	

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F 867	Continued From page 23 During the complaint investigation dated 10/13/21, the facility failed to implement the care plan interventions for falls and failed to modify the interventions after each fall to prevent further falls for 2 of 3 sampled residents reviewed for accidents. An interview was completed on 9/13/23 at 3:20 PM with the Administrator. She stated it was obvious that the facility had issues with the MDS coding and care planning and stated she was uncertain why the failure continued but acknowledged it was human error. The Administrator stated the repeat citation for accidents were unrelated but felt the repeat citation for accidents was due to staff turnover.	F 867	software, and electronic health records to benchmark ourselves. This benchmarking will allow us to identify opportunities to assist us and define resident focused goals, We will use data to monitor our performance. Staff training on the Quality assurance Performance Improvement policy will be included in orientation. This will include QAPI principles and staff responsibilities related to QAPI and ongoing quality improvement. How the corrective actions will be monitored: Facility Administrator will review all QAPI reports monthly with the QAPI members to ensure all identified areas of concern and trends that are noted through observation, grievances, the resident at risk meeting, and our audits tools are documented to formulate action plans as identified. The results of the action plans will be reviewed in Quality Assurance Performance Improvement Meeting for six month if resolved. The QA Committee will dentify any trends or patterns and make recommendations to revise the plans as necessary. The QAPI Committee will develop systematic procedures and new approaches to monitor smokers and ensure fall interventions are in place as ordered. Monthly call with MDS Nurse Consultant monthly to review progress toward resolving repeat citations for three months. The Senior Nurse Consultant will review QAPI Committees progress and make	

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F 867	Continued From page 24	F 867	changes to the committees approach to to ensure progress occurs and facility is in substantial compliance.	