STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING ______ B. WING ______	C 09/28/2023

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	**205 RATTLESNAKE TRAIL PINEHURST, NC 28374**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/25/23 through 09/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #N1OD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 9/25/23 through 9/28/23. Event ID# N1OD11. The following intakes were investigated NC00194952, NC00196700, NC00197701, NC00197720, NC00198330, NC00202047, NC00206041, NC00206794 and NC00206964. 6 of the 31 complaint allegations resulted in deficiency.	F 000		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		10/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 625	Continued From page 1 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide written notification regarding bed hold to the resident's responsible party when residents were hospitalized for 3 of 3 residents reviewed for hospitalization (Residents #43, #45 and #73). The findings included: 1) Resident #43 was initially admitted to the facility on 5/8/21. Resident #43's medical record indicated she was transferred to the hospital on 8/7/23. On 8/11/23 she was readmitted to the facility. A quarterly Minimum Data Set (MDS) assessment dated 8/14/23, revealed Resident #43 to be cognitively intact. On 9/27/23 at 11:09 AM, an interview occurred with Nurse #1 who stated she was unaware of a bed hold policy being sent when a resident went to the hospital by the nursing department. The Business Office Manager was interviewed on 9/27/23 at 11:15 AM and stated she was unaware	F 625	All items listed on this self-imposed action plan have been completed and implemented on 10/18/23 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/23. 1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: The facility failed to provide written notification regarding the facility bed hold policy to Residents #43, 45 & 73 or their responsible party when the resident was hospitalized. 2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED: All residents under Medicare or Private Pay status could be affected by this alleged deficient practice. A focused review was completed by the Administrator on 9/28/23 regarding use of the facility's Bed Hold policy for the previous month. The focused review revealed that six residents discharged to the hospital had not received a Bed Hold	

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F 625	Continued From page 2 of a bed hold policy having to be sent to the resident and/or Responsible Party (RP) when a resident was hospitalized. On 9/27/23 at 11:17 AM, an interview was conducted with the Social Worker. She was unaware of a bed hold policy having to be provided to the resident and/or RP when a resident was hospitalized. The Admissions Director was interviewed on 9/27/23 at 12:42 PM, and stated she only reviewed the bed hold policy on admission. She was not responsible for providing the bed hold policy to the resident and/or RP when a resident was hospitalized. An interview occurred with the Administrator on 9/27/23 at 2:00 PM, who stated that currently the bed hold policy was not being provided to the resident and/or RP when a resident was hospitalized. She felt that with the recent turnover in staffing the task just got left off. The Administrator stated a process would be put into place regarding the written notification to be provided when a resident was hospitalized. 2) Resident #45 was initially admitted to the facility on 5/19/21. A quarterly MDS assessment, dated 7/21/23, revealed Resident #45 was cognitively intact. Resident #45's medical record indicated he was transferred to the hospital on 9/2/23 and readmitted to the facility on 9/8/23. On 9/27/23 at 11:09 AM, an interview occurred	F 625	Policy Form. 3. MEASURES FOR SYSTEMIC CHANGE: On 9/27/23 a binder containing Bed Hold and Return Agreement forms was placed at each nursing station and nursing staff working that day were educated on Bed Hold Policy and how to complete the forms. On 10/12/23 the Unit Manager pre-populated Bed Hold and Return Agreement forms with room rate information and redistributed forms to each nurses' station. On 10/12/23, the DON and Unit manager educated all licensed nurses regarding the Bed Hold and Return Agreement. Nursing staff that were not available for education will be educated upon return to work prior to accepting an assignment. 4. HOW CORRECTIVE ACTION WILL BE MONITORED: All hospital discharges will be discussed in morning IDT meeting. The clinical team will ensure that a bed hold form was completed and that social work sent notice of discharge letter to resident/family. This monitoring process will take place each weekday for 4 weeks, then once weekly for two months. Any issues during monitoring will be addressed immediately. The Administrator or DON will report findings of the monitoring process to the facility QAPI Meeting for three months and will determine if any additional monitoring or modification of this plan is necessary to maintain compliance.	

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F 625	Continued From page 3	F 625		

with Nurse #1 who stated she was unaware of a bed hold policy being sent when a resident went to the hospital by the nursing department.

The Business Office Manager was interviewed on 9/27/23 at 11:15 AM and stated she was unaware of a bed hold policy having to be sent to the resident and/or Responsible Party (RP) when a resident was hospitalized.

On 9/27/23 at 11:17 AM, an interview was conducted with the Social Worker. She was unaware of a bed hold policy having to be provided to the resident and/or RP when a resident was hospitalized.

The Admissions Director was interviewed on 9/27/23 at 12:42 PM, and stated she only reviewed the bed hold policy on admission. She was not responsible for providing the bed hold policy to the resident and/or RP when a resident was hospitalized.

An interview occurred with the Administrator on 9/27/23 at 2:00 PM, who stated that currently the bed hold policy was not being provided to the resident and/or RP when a resident was hospitalized. She felt that with the recent turnover in staffing the task just got left off. The Administrator stated a process would be put into place regarding the written notification to be provided when a resident was hospitalized.

3) Resident #73 was initially admitted to the facility on 5/31/23.

Resident #73's medical record indicated the following:

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- She was transferred from the facility on 7/10/23 and admitted to the hospital. She was readmitted to the facility on 7/25/23.
- She was transferred from the facility on 8/21/23 and admitted to the hospital. She was readmitted to the facility on 8/28/23.

A quarterly MDS assessment dated 9/7/23 indicated Resident #73 had moderately impaired cognition.

On 9/27/23 at 11:09 AM, an interview occurred with Nurse #1 who stated she was unaware of a bed hold policy being sent when a resident went to the hospital by the nursing department.

The Business Office Manager was interviewed on 9/27/23 at 11:15 AM and stated she was unaware of a bed hold policy having to be sent to the resident and/or Responsible Party (RP) when a resident was hospitalized.

On 9/27/23 at 11:17 AM, an interview was conducted with the Social Worker. She was unaware of a bed hold policy having to be provided to the resident and/or RP when a resident was hospitalized.

The Admissions Director was interviewed on 9/27/23 at 12:42 PM, and stated she only reviewed the bed hold policy on admission. She was not responsible for providing the bed hold policy to the resident and/or RP when a resident was hospitalized.

An interview occurred with the Administrator on 9/27/23 at 2:00 PM, who stated that currently the bed hold policy was not being provided to the resident and/or RP when a resident was

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F 625	Continued From page 5 hospitalized. She felt that with the recent turnover in staffing the task just got left off. The Administrator stated a process would be put into place regarding the written notification to be provided when a resident was hospitalized.	F 625		
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 reviews, resident and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of bathing for 1 of 20 residents reviewed (Resident #6). The findings included: Resident #6 was admitted to the facility 6/21/22 with diagnoses that included muscle weakness, low back pain, and chronic pain. A review of the shower records from 7/16/23 to 7/22/23 revealed Resident #6 was provided a bed bath on 7/21/23. The most recent Minimum Data Set (MDS) assessment dated 7/22/23 indicated Resident #6 had moderately impaired cognition. The bathing section was coded as the activity did not occur during the seven-day look back period. On 9/25/23 at 12:30 PM, Resident #6 was interviewed. She explained that she preferred to have bed baths and sponge baths rather than showers. Resident #6 also stated that a sponge	F 641	All items listed on this self-imposed action plan have been completed and implemented on 10/19/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/20/2023. 1. Corrective action to be accomplished: Resident #6 was found to have inaccurate coding in the area of bathing on 7/22/23 and was corrected and coded accurately on the minimum data set by the Minimum Data Set Coordinator on 9/28/23. 2. Measures taken to identify other residents affected: A focused review was completed by the Minimum Data Set Coordinator on 9/28/23 regarding the accuracy of coding on the minimum data set in accordance with the resident assessment instruments for all residents over the past 3 months for bathing coding. Focused review revealed no other bathing coding discrepancies. This focused review was subsequently	10/19/23

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bath was provided daily before she got up to her wheelchair. She was able to wash some of her upper body but became fatigued very easily with pain in her joints.

An interview was completed with Nurse Aide (NA) #1 on 9/27/23 at 12:43 PM. She was familiar with Resident #6 and assigned to care for her on the day shift (7:00 AM to 3:00 PM). She explained Resident #6 was offered a shower twice a week on day shift but normally refused them and received a bed bath instead. NA #1 further stated a sponge bath was provided in the mornings before assisting Resident #6 up to her wheelchair and she required extensive assistance with the task.

On 9/28/23 at 9:05 AM, an interview occurred with NA #2 who was familiar with Resident #6 and assigned to care for her on the day shift. She explained that Resident #6 was provided a bed bath every morning before getting up to her wheelchair and required extensive assistance with the task.

The MDS Coordinator was interviewed on 9/28/23 at 9:45 AM, reviewed the MDS dated 7/22/23 and verified the bathing portion of the MDS was marked as the activity did not occur. She explained the bathing portion of the assessment was coded based on the Activities of Daily Living charting completed by the NAs for bathing and there should have been some observations and interviews completed with the resident and staff to determine the amount of assistance required for the bathing task.

An interview occurred with the Director of Nursing on 9/28/23 at 10:30 AM and indicated it was her

F 641

audited by the Director of Nursing on 10/18/23, and verified to be accurate.
3. Measures for systemic change:
To protect residents from similar occurrences, the DON provided re-education to the Minimum Data Set Coordinators regarding the need for accurate coding on the minimum data set to reflect accurate coding for bathing.
4. How corrective action will be monitored:
Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
An audit sheet will be used by the DON or designee to monitor and ensure that all bathing was coded accurately on the MDS. This monitoring process will take place 2 x per week for 4 weeks, then monthly for two months.
Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility QAPI Meeting for three months and will determine if any additional monitoring or modification of this plan is necessary to maintain compliance.

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F 641	Continued From page 7 expectation for the MDS to be coded accurately.	F 641		
F 657 SS=B	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. (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 revise the care plan for an antidepressant medication (#73) and for bed mobility (Resident #68). This was for 2 of 20 residents reviewed.	F 657	All items listed on this self-imposed action plan have been completed and implemented on 10/18/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any	10/19/23

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The findings included:

1) Resident #73 was initially admitted to the facility on 5/31/23 with diagnoses that included a history of a stroke, dementia, and depression.

The medical record for Resident #73 was reviewed and indicated Venlafaxine (a medication used to treat depression) 75 milligrams (mg) by mouth twice a day was discontinued on 7/11/23.

Resident #73's active care plan, last reviewed 8/14/23, included a focus area for "uses antidepressant medication (Venlafaxine) related to depression".

A review of the September 2023 Medication Administration Record revealed Resident #73 did not receive any type of antidepressant medication.

On 9/28/23 at 9:45 AM, an interview occurred with the Minimum Data Set (MDS) Coordinator. After reviewing Resident #73's active care plan and medical record she confirmed the antidepressant medication was discontinued on 7/11/23 and should have been resolved from the care plan when it was reviewed on 8/14/23. She felt it was an oversight.

The Director of Nursing was interviewed on 9/28/23 at 10:30 AM and indicated it was her expectation for the care plan to be an accurate representation of the resident.
2. Resident #68 was admitted on 2/10/23 with a diagnosis of cerebral ischemia.

Review of Resident #68's last two quarterly

F 657

potential citation associated with this action plan should be considered past noncompliance as of 10/19/2023.
1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Facility failed to revise a care plan for an antidepressant (Resident #73) and bed mobility (Resident #68). The antidepressant prescribed for Resident #73 was discontinued on 7/11/23 but was not updated on the care plan review completed on 8/14/23. Resident #68 was extensive assist with bed mobility but was erroneously coded as requiring supervision. MDS Director & DON corrected the care plans on 9/28/23.

2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED: A focused review of five additional resident care plans was completed by the Minimum Data Set Coordinator on 10/18/23 regarding the accuracy of care plans in accordance with the current and discontinued orders for those residents over the past month. Focused review revealed no other discrepancies. This focused review was subsequently audited by the Director of Nursing on 10/19/23 and verified to be accurate.

3. MEASURES FOR SYSTEMIC CHANGE: To ensure future care plan accuracy, the DON provided re-education to the Minimum Data Set Coordinators on need for timely care plan revisions. Care plan updates will be completed in the daily IDT Clinical meeting by MDS, DON or Unit Manager.

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F 657	Continued From page 9 Minimum Data Set (MDS) assessments dated 5/20/23 and 8/20/23 indicated he was coded for extensive assistance with two staff for bed mobility. Resident #68's comprehensive care plan last revised on 9/14/23 read his bed mobility required supervision assistance by one staff to turn and reposition in bed as necessary. An interview was completed on 9/28/23 at 9:43 AM with the MDS Nurse. She stated Resident #68's care plan should have been revised to reflect his need of two staff extensive assistance with bed mobility. An interview was completed with the Administrator and the Director of Nursing on 9/28/23 at 10:30 AM. The Administrator stated Resident #68's care should have been revised to reflect that he required extensive assistance of two staff with his bed mobility.	F 657	4. HOW CORRECTIVE ACTION WILL BE MONITORED: An audit sheet will be used by the DON or designee to monitor and ensure that care plans are correct and up to date. This monitoring process will take place 2 x per week for 4 weeks of five randomly chosen care plans, then monthly for two months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility QAPI Meeting for three months and will determine if any additional monitoring or modification of this plan is necessary to maintain compliance.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		10/19/23

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews with staff, Physician Assistant (PA), Wound Nurse Practitioner, and Medical Director (MD), the facility failed to implement preventative measures for a resident assessed to be moderate to high risk for development of pressure ulcers. The resident developed a deep tissue injury to the sacrum, 2 deep tissue injuries to the left lateral foot, as well as a deep tissue injury to the left ankle. Deterioration of the sacral wound was not communicated to the MD or the PA. The resident was admitted to the hospital with septic shock for 1 of 8 residents (Resident #178) reviewed for pressure injuries.

The findings included:

Hospital discharge summary indicated Resident #178 was previously living in an assisted living environment for 100+ days prior to being seen in the Emergency Department on 7/24/2023 for acute onset mental status change thought to be caused by a urinary tract infection. The resident was discharged from the hospital to the skilled nursing facility for short term rehabilitation.

Resident #178 was admitted to the facility 8/1/2023 with diagnoses that included type 2 diabetes, coronary artery disease, hypertension (high blood pressure), altered mental status with recent history of urinary tract infection.

The resident's admission Minimum Data Set dated 8/7/2023 indicated the resident did not have any pressure injuries upon admission. The resident was coded as moderately cognitively

F 686

All items listed on this self-imposed action plan has been completed and implemented on 10/18/23 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/23.
1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: The facility allegedly failed to implement preventative measures for a resident at moderate to high risk for development of pressure ulcers. Resident #178 no longer resides in the facility.
2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED: All residents with moderate to high risk for developing pressure injuries could be affected by the alleged deficient practice. Nursing management completed a 100% audit of all current residents with wounds on 10/18/23 to ensure that the Physician had been notified of current wound status, and that appropriate interventions were in place to prevent further deterioration of wounds.
3. MEASURES FOR SYSTEMIC CHANGE: Education was provided to the Wound Nurse Practitioner by the Director of Nursing on 9/28/23 regarding notification of new wounds and deterioration of wounds to the providers and the dietician. The DON & Unit Managers provided education to all licensed nurses on Wound Care

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 686	Continued From page 11 impaired and required extensive assistance with bed mobility, eating, dressing, and personal hygiene during the assessment period. The resident was always incontinent of bowel and bladder. The resident's admission care plan dated 8/2/2023 contained a focus for risk of skin impairment related to incontinence and being in bed or geriatric chair. Interventions included; resident needs pressure relieving mattress on bed to protect the skin while in bed. The intervention was dated 8/9/2023. Per Unit Manger #1The resident was provided a pressure relieving mattress on 8/9/2023. On 8/3/2023 the Wound Nurse Practitioner (NP) completed Resident #178's admissions skin assessment. Her progress note indicated the resident's skin was intact and he was moderate to high risk for skin breakdown. The Wound NP recommended moisture barrier creams and turning /repositioning to prevent pressure injuries. The resident's medical record contained the following active orders; Give resident health shake twice daily. The order had a start date of 8/6/2023. The medical record contained a weekly skin assessment completed 8/8/2023. The skin was intact. The resident's medical record contained a progress noted dated 8/13/2023 by Nurse #5 indicated the resident had a "new open area on coccyx measuring approx. 4 centimeters (cm) long". She notified the provider on call and received orders to clean and cover the wound with a foam dressing every other day and as	F 686	prevention and treatment to include interventions to prevent the development of wounds and the deterioration of wounds. Nursing staff that were not available for education or are new hires will be educated upon return to work prior to accepting an assignment. 4. HOW CORRECTIVE ACTION WILL BE MONITORED: The Wound Nurse Practitioner is to provide a written weekly update to the Director of Nursing, Medical Providers and Registered Dietitian for all wounds. The Director of Nursing or designee will audit all wounds weekly in Risk Meeting to ensure that interventions are in place as indicated for three months. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for three months. The audits will continue at the discretion of the QAPI committee.	

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needed until the wound could be evaluated by the Wound NP. There was no other description of the wound.

Attempts to contact Nurse #5 were not successful.

Resident #178's Treatment Administration Record (TAR) for August revealed the resident received wound care per the order given by the provider on 8/13/2023.

On 8/15/2023 the Wound NP evaluated Resident #178. The visit summary indicated the resident had the following pressure injuries;

Left lateral foot deep tissue injury, length 2.3cm x width 2.5cm x depth 0
Left ankle deep tissue injury, 1.2cm x 1.3cm x 0
Sacrum deep tissue injury, 3cm x 1.8cm x 0.2cm with moderate serosanguinous exudate

The Wound NP recommended cleaning and application of skin preparation for the left lateral foot and left ankle, as well as leaving both open to air. She recommended cleaning, medical grade honey, and hydrocolloid, and dressing changes 3 times a week for the sacral deep tissue injury.

The resident's medical record contained the following active orders;
Cleanse sacral wound with wound cleanser, apply medical grade honey, cover with hydrocolloid three days per week and as needed. The order had a start date of 8/16/2023.

Cleanse left lateral foot wounds with wound cleanser, apply skin prep, leave open to air daily.

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The order had a start date of 8/16/2023.

Cleanse left ankle wound with wound cleanser, apply skin prep, leave open to air daily. The order had a start date of 8/16/2023.

The resident's Treatment Administration Record (TAR) for August indicated the resident received treatments to his pressure injuries as ordered.

On 8/22/2023 the Wound NP evaluated Resident #178's pressure injuries. The after-visit summary documented the following;

Left lateral distal foot deep tissue injury, 2.7cm x 1.9cm x 0
Left lateral foot deep tissue injury, 1.2cm x 1.3cm x 0
Left ankle, deep tissue injury, 1.2cm x 1.3cm x 0
Sacrum deep tissue injury, 10cm x 8cm x .2cm with moderate serosanguinous exudate

Recommendations for treatment of existing pressure injuries did not change from previous week. Wound care orders for the new deep tissue injury to the foot included cleaning, application of skin preparation, and leaving the wound open to air. The Wound NP recommended the staff continue turning and repositioning.

The resident's August TAR revealed the resident received treatments to his pressure injuries as ordered.

On 8/22/2023 the resident's medical record indicated he was febrile at 102 degrees and received Tylenol.

The Medical Director (MD) evaluated Resident

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F 686	Continued From page 14 #178 on 8/23/2023 for suspected pituitary adenoma due to a very low thyroid stimulating hormone (TSH) level, low T3 (thyroid hormone) with normal T4 (thyroid hormone) . She documented cognitive decline since her previous evaluation one week prior. The MD spoke with the resident's Responsible Party (RP) who was concerned about the resident's cognitive decline over the previous 4 days. The MD documented the resident was difficult to arouse. She ordered labs including COVID-19, clostridium difficile, and made referral to endocrinology. A progress note indicated the resident's RP visit the facility on 8/23/2023 at 2:14 PM and requested the resident be sent out to the Emergency Department. Hospital records dated 8/23/2023 indicated the resident arrived at the Emergency Department febrile at 101 degrees, hypotensive (low blood pressure) at 98/36, and minimally responsive to stimuli. The medical record also indicated the resident had a large foul smelling unstageable sacral wound. There was no documentation regarding the deep tissue injuries to the left foot and ankle. The Emergency Department physician noted the resident was too unstable too thoroughly evaluate the wound in the Emergency Department. The resident was admitted to the Intensive Care Unit with a diagnosis of septic shock and required pressors (intravenous medication to support blood pressure). Hospital records also contained a consult by Infectious Disease. The Infectious Disease Physician indicated while the resident tested positive for COVID-19, there was no sign of pulmonary infiltrates on chest x-ray. He did not	F 686		

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feel like COVID was contributing to his illness. Polymicrobial soft tissue infection of the sacral region was most likely the cause of his sepsis. Cultures were positive for Enterococcus and Staphylococcus.

An interview with Nurse Assistant (NA) #3 was conducted 9/26/2023 at 9:45 AM. She stated she occasionally worked on the hall Resident #178 resided. She vaguely recalled the resident but did not recall his pressure injuries.

NA#4 was assigned to the hall Resident #178 resided on during his stay. She stated she did not recall Resident #178. She stated the residents on that hall were short term and it was difficult to remember them all.

On 9/27/2023 at 1:26 PM an interview was conducted with the MD. She stated she completed labs and ordered a dietary consult on admission. She further stated the resident's albumin was a little low at 3.4 on admission and he was diabetic. Those could have contributed to the development of pressure injuries. The MD stated she did not know why the resident's sacral pressure injury would have declined so quickly. She stated the Wound NP had not communicated the deterioration of the sacral wound to her. The Wound NP may have communicated with the facility's Physician Assistant regarding the wound.

An interview was conducted with the Physician Assistant (PA) on 9/27/23 at 2:01 PM. He stated he was aware the resident had developed wounds around 8/13/2023. The PA stated the resident was not able to move himself in the bed or reposition himself in a wheelchair. He had spoken with the resident's family regarding the

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resident's decreased cognition and need for imaging. The resident had imaging completed on 8/15/2023 that was negative for cerebral vascular accident (stroke). The PA stated the Wound NP had not made him aware of the deterioration of the sacral wound and he was not aware it was significant enough to cause sepsis.

On 9/27/2023 at 3:00 PM an interview was conducted with Unit Manager#1. Unit Manager #1 stated she performed the resident's wound care while he was in the facility. She recalled the wound was necrotic, had exudate, and declined rapidly. She stated she did rounds with the Wound NP on 8/15/2023 and they discussed placing the resident on a specialty mattress. She was in the process of determining if he met the criteria for a gel overlay or air mattress when the resident was sent to the hospital.

The Unit Manager #1 provided an paper form titled, " IDT Post Wound Investigation Summary" that was dated 8/12/2023 10:37PM. The form indicated the care plan decision was to get gel overlay to bed. The form was signed by Unit Manager #1. Unit Manager #1 stated she was not sure why the gel overlay was not provided.

Unit Manager #1also provided a paper form titled, "IDT Post Wound Investigation Summary" dated 8/19/2023 10:09PM. The care plan decision indicated possible air mattress if appropriate. Unit Manager #1 stated the resident did not meet the criteria for an air mattress. She further stated the resident was able to move himself independently in the bed. This made an air mattress a falls risk.

A telephone interview was conducted with the Wound NP on 9/27/2023 at 3:15 PM. Stated the

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F 686	Continued From page 17 resident's sacral wound deteriorated rapidly. It was a DTI with necrosis. She did not recall if it had an odor but stated it did have some exudate. She was not concerned with the rapid deterioration of the wound. She was going to give the wound another week to "declare itself". At the time of the interview, she was not aware the resident had been admitted to the hospital with septic shock related to the sacral wound. On 9/27/23 at 3:43 PM the Wound NP called back and stated when a sacral DTI deteriorates rapidly, she would typically recommend changing treatments, adding an air mattress, and recommending dietary add protein supplements. She did not recall if any of these interventions were started because she did not order interventions, she was only responsible for the actual wound care. She stated she did not recall speaking with the Physician Assistant or the Medical Director regarding the sacral wound deterioration as she was not always in the facility at the same time as the providers.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		10/19/23

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F 688	Continued From page 18 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to apply a left lower extremity (LLE) brace as ordered. This was for 1 (Resident #44) of 1 resident reviewed for range of motion (ROM). The findings included: Resident #44 was admitted on 2/26/20 with a diagnosis of a Cerebral Vascular Accident (CVA) and multiple contractures. Resident #44's annual Minimum Data Set (MDS) dated 7/6/23 indicated severe cognitive impairment, no behaviors, extensive assistance with all of her activities of daily living and she was coded for impairment to both upper and lower extremities. Review of Resident #44 September 2023 Physician orders included an order dated 8/22/23 and reordered on 9/25/23 that read she was to wear a knee brace on her LLE for 4 hours a day, or as tolerated while lying supine in the bed for contracture management. Resident #44 was care-planned for a self-care performance deficit which included the new intervention dated 8/23/23 to wear the knee brace on her LLE for 4 hours a day, or as tolerated while lying supine in bed. A review of the comprehensive care plan did not include any	F 688	All items listed on this self-imposed action plan have been completed and implemented on 10/18/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/2023. 1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: The facility failed to apply left lower extremity (LLE) brace as ordered for resident #44. Resident was ordered to wear knee brace to LLE for 4 hours a day or as tolerated, while lying supine in bed for contracture management. Resident #44 has had order added to eTAR for nurses to sign off on donning and doffing of brace as ordered. Resident #44 is currently having brace applied per order. 2. Measures taken to identify other residents affected: The DON updated all current orders of residents with braces/splinting devices to include a schedule for the nurse to document application of the brace/splint on the MAR. If the resident refuses and splint device is not applied, a progress note will populate for the nurse to	

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refusals or resistance to wearing her LLE brace.

Review of Resident #44's undated electronic Care Guide read the following: Resident was to wear knee brace on LLE for 4 hours or as tolerated daily while lying supine.

An observation was completed on 9/25/23 at 12:14 PM of Resident #44. She was lying supine (lying in bed with face upward) in bed with no LLE brace in use.

Another observation was completed on 9/26/23 at 11:12 AM of Resident #44. She was lying supine in bed with no LLE brace in use. Resident #44 stated she was supposed to wear the LLE brace everyday but the staff were inconsistent with putting it on her. Observation of Resident #44's closet revealed the LLE brace lying on the bottom of the closet with a pillow on top of it.

An interview was completed on 9/27/23 at 9:15 AM with Nursing Assistant (NA) #6, who had worked with Resident #44. She stated she was aware that Resident #44 was ordered an LLE brace and she was not known to refuse the LLE brace.

Another observation was completed on 9/27/23 at 9:25 AM of Resident #44. She was lying supine in the bed with no LLE brace in use and observed on top of a nightstand beside her closet was her LLE brace.

An interview was completed on 9/27/23 at 9:30 AM with the Therapy Director. He stated Resident #44's LLE brace was a new intervention and was recently put into place on 8/22/23. and she was discharged from Physical Therapy (PT) on

F 688

complete.

3. MEASURES FOR SYSTEMIC CHANGE:
Therapy was advised to notify Nursing Management when a resident discharges from therapy services with orders for a brace/splint so that order accuracy can be confirmed in PCC. The DON, and Unit Manager provided education for licensed nurses and CNAs regarding process for ensuring that braces and splinting devices are in place as ordered and documentation reflects application as well as refusals.
Nursing staff that were not available for education will be educated upon return to work prior to accepting an assignment.

4. HOW CORRECTIVE ACTION WILL BE MONITORED:
The DON, ADON, Unit manager will perform order audits for all residents discharged from therapy with splints/braces within 24 hours.
The DON, ADON, Unit Manager will perform random audits of resident orders with splints/braces 3 x per week for 4 weeks, then 2 x per week for 2 months.
The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The DON or ADON will review the plan during the monthly QAPI meeting for three months, and the audits will continue at the discretion of the QAPI committee.

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F 688	Continued From page 20 9/14/23. The Therapy Director provided a therapy note dated 9/14/23 which read the following: demonstrated and practiced with the aide donning Resident #44's LLE to reduce her hip and knee flexion contracture. Resident #44 was reminded she was to wear the LLE brace for 4 hours a day while lying supine in bed. The Therapy Director stated when therapy discharged a resident from therapy, they complete written instructions that were provided to nursing department on new interventions implemented. He provided a copy of a form titled "Post Discharge Nursing Staff Care Services Communication Form" dated 9/15/23 read as follows: Resident #44 had to wear her knee brace on her LLE fir 4 hours or as tolerated daily while supine in bed. The form was not signed by any staff in the nursing department. Review of Resident #44's nursing notes from 8/22/23 to 9/27/23 did not include any documented evidence of her refusing to wear her LLE brace as ordered. Review of the Nurse Aides task documentation for September 2023 did not include any evidence that Resident #44's LLE brace was being applied as ordered. Review of Resident #44's Medication Administration Records (MARs) for August and September 2023 read the following information: Resident #44 was to wear the LLE brace for 4 hours or as tolerated daily while lying supine in bed for contracture management. There was no place for the nurse to document the ordered application and removal of her LLE brace was completed.	F 688		

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F 688	Continued From page 21 The Director of Nursing (DON) provided a copy of a nursing note dated 9/26/23 at 3:45 PM as only documented evidence from 8/23/23 to present that the nursing staff were applying Resident #44's LLE brace as ordered. An interview was completed on 9/27/23 at 1:55 PM with Nurse #4. She stated Resident #44 was to wear the LLE brace when supine in bed. Nurse #4 stated the aides put on and remove her LLE brace. Nurse #4 stated she was not aware that the application of Resident #44's LLE brace appeared on the September 2023 MAR. She stated since it was on the MAR, the nurse was responsible for ensuring the aide applied the brace as ordered however that there was no place to document it. She stated it appeared on the MAR as an FYI . Nurse #4 stated none of the aides had reported to her any occasion that Resident #44 refused to wear her LLE brace. An interview was completed on 9/27/23 at 2:00 PM with NA #7 who was assigned to Resident #44. She stated she was unaware that Resident #44's was ordered to wear LLE brace to be worn daily and she had not been applying it. An interview was completed on 9/27/23 at 2:20 PM with the DON. She stated she added the application of Resident #44's LLE brace to the aides daily task list and it would now populate for the aides to document her LLE brace placement, removal and refusals. The DON stated Resident #44's LLE brace should have been applied as ordered for contracture management. An observation was completed on 9/28 at 930 AM of Resident #44. She was lying supine in bed wearing her LLE brace.	F 688		

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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 staff and Hospice Aide #1 interviews along with record review, the facility failed to provide care safely which resulted in a fall without injury when Hospice Aide #1 left Resident #68's on his side in bed to retrieve a washcloth and failed to ensure two staff were presence for bed mobility. This was for 1 (Resident #68) of 8 reviewed for accidents. The findings included: Resident #68 was admitted on 2/10/23 with a diagnosis of cerebral ischemia. Review of Resident #68's Fall Risk Assessment dated 5/12/23 indicated he was a moderate risk for falls, no history of falls and required the presence of 1-2 staff. Review of the incident report read Resident #68 sustained a fall on 7/27/23 when Hospice Aide #1 independently positioned him on his side and stepped away from the bedside to retrieve a washcloth resulting in a fall with no injury. The new intervention implemented was to ensure Resident #68 was repositioned on his back when not providing ADL care. Review of Resident #68's Fall Risk Assessment	F 689	All items listed on this self-imposed action plan have been completed and implemented on 10/19/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/20/2023. 1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Resident #68 sustained a fall on 7/27/23 when hospice aide positioned him on his side and stepped away from the bedside to retrieve a washcloth. This resulted in a fall with no injury. Resident required two staff members for bed mobility, however the hospice aide did not have a second staff member present during care. No harm was caused to resident #68 due to the incident. The hospice aide received education the day of the incident (7/27/23) from both her supervisor and facility Director of Nursing regarding not leaving resident unattended on their side and having two staff members present when turning and repositioning. Resident care plan was revised by DON to reflect two	10/20/23

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completed after his fall dated 7/27/23 indicated he was a high risk for falls, no history of falls and required the presence of 1-2 staff.

Review of Resident #68's last two quarterly Minimum Data Set (MDS) assessments dated 5/20/23 and 8/20/23 indicated he was coded for extensive assistance with two staff for bed mobility.

Resident #68 comprehensive care plan last revised on 9/14/23 read his bed mobility required supervision assistance by one staff to turn and reposition in bed as necessary for his activities of daily living (ADLs).

An interview was completed on 9/26/23 at 2:40 PM with the Director of Nursing (DON). She stated she completed one-on-one education with Hospice Aide #1 and the aide notified the hospice agency of the fall. The DON stated Hospice Aide #1 rolled Resident #68 onto his side and then stepped away from the bedside to grab something to provide incontinence care. The DON stated she educated Hospice Aide #1 to return Resident #68 onto his back if she needed to step away from the bedside.

An interview was completed on 9/27/23 at 9:20 AM with Nursing Assistance (NA) #7. She stated Hospice Aide #1 came to provide Resident #68's ADL assistance Monday through Friday. She stated Resident #68 did require two staff assistance with turning and repositioning in bed especially with pulling him up in bed. NA #7 stated residents should never be left alone on their side while staff stepped away from the bedside and should always have another staff member present if the residents required two staff

F 689

person assist with turning and repositioning in bed.

2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED: All hospice residents have the potential to be affected by this alleged deficient practice. A Kardex audit of current hospice residents was completed by the Director of Nursing & District Director of Clinical Services for current Hospice residents on 10/20/23.

3. MEASURES FOR SYSTEMIC CHANGE:
The Director of Nursing and Unit manager completed education on 10/19/23, for licensed nurses and nursing aides. The Kardex is to be used as a reference to ensure staff are utilizing correct assistance with basic Activities of Daily Living. As of 10/20/23, Hospice leadership was educated regarding access to binders at the nurse's station to reference the care specific to their client(s). Any updates to the Kardex will be placed in the binder by the DON or Unit Managers. Nursing staff that were not available for education or are new hires will be educated upon return to work prior to accepting an assignment.

4. HOW CORRECTIVE ACTION WILL BE MONITORED:
The DON, ADON, Unit manager will perform random room audits 3 x week for 4 weeks, then 3 x week for two months to observe bed mobility with proper staff assistance.
The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain

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assistance with their bed mobility due to increased risk of the resident sustaining a fall.

A telephone interview was completed on 9/27/23 at 9:48 AM with Hospice Aide #1. She stated Resident #68 was in his bed. Hospice Aide #1 stated she was washing him up when she rolled Resident #68 onto his side and stepped away from his bedside to grab a washcloth. She stated she tried to grab him to stop the fall but there was nothing to really grab onto. She stated after the fall, she notified her supervisor at the hospice agency and also the DON for the facility. She stated she received re-education from both her hospice supervisor and the facility DON regarding not leaving a resident unattended on their side. She stated at one time, hospice was sending two aides to the facility but then it changed to one due to staffing. Hospice Aide #1 stated about month ago, the agency resumed sending two aides.

An interview was completed on 9/27/23 at 11:25 AM with NA #1. She stated Resident #68 always required two staff assistance bed mobility because of how his right side and right leg were contracted and difficult to safely move alone.

Another interview was completed with the DON on 9/28/23 at 9:40 AM. She stated she was not aware that Resident #68 was coded for extensive assistance of two staff with his bed mobility until 9/27/23 when she revised his care plan to reflect his bed mobility status to reflect he required to staff present with turning and positioning in the bed.

An interview was completed on 9/28/23 at 8:30 AM with the Administrator. She stated it was the responsibility of the facility to ensure Resident

compliance. The DON or designee will review the plan during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will continue at the discretion of the QAPI committee.

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F 689	Continued From page 25 #68 not sustain any falls and to ensure there were two hospice aides or the hospice aide to obtain a facility staff member to assist her with Resident #68's bed mobility if the second hospice aide was not available. The Administrator stated there were two hospice aides coming now to provide Resident #68's ADL assistance.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, Physician Assistant and staff interviews, the facility failed to transcribe pulse parameters for a heart medication for 1 of 5 residents whose medications were reviewed	F 757	All items listed on this self-imposed action plan have been completed and implemented on 10/19/2023 with ongoing monitoring to ensure compliance. This	10/20/23

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(Resident #73).

The findings included:

Resident #73 was initially admitted to the facility on 5/31/23 with diagnoses of hypertension, presence of a cardiac implant and atrial fibrillation.

A physician's progress note dated 7/26/23 indicated that Digoxin 125 micrograms (mcg) was being provided daily for atrial fibrillation and should be held for a pulse rate less than 60.

A review of the August 2023 physician orders revealed an order dated 7/26/23 for Digoxin 125 mcg 1 tablet by mouth daily for atrial fibrillation. Hold for pulse less than 60.

Review of the August 2023 Medication Administration Record (MAR) from 8/1/23 to 8/21/23 indicated the pulse rate was being monitored when the Digoxin was administered. There were no days that Resident #73's pulse was below 60 and the Digoxin was held.

A review of the medical record indicated Resident #73 was admitted to the hospital on 8/21/23 and was readmitted to the facility on 8/28/23. Per the hospital discharge summary dated 8/28/23 an order was present for Digoxin 125 mcg 1 tablet by mouth daily in the morning.

An interview occurred with Nurse #2 on 9/26/23 at 1:47 PM as she was the nurse who transcribed the Digoxin order when Resident #73 was readmitted to the facility on 8/28/23. She reviewed the August 2023 Digoxin orders and confirmed she failed to include when to hold the

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concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/20/2023.
1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:
Resident #73 was initially admitted to the facility on 5/31/23 with orders for Digoxin and the facility failed to transcribe pulse parameters for this medication. She readmitted on 8/28/23 and the facility failed to include hold parameters for this medication.
On 9/26/23, the Director of Nursing revised resident #73 order for Digoxin to include parameters to hold for pulse less than 60 beats per minute.
2. MEASURES to identify other residents affected:
An audit was conducted of ALL residents in the facility on 9/27/23, and there was one other resident found to be on Digoxin with no hold parameters in place. This residents order was revised on 9/27/23 by the DON to include parameters to hold for pulse less than 60 beats per minute.
3. MEASURES FOR SYSTEMIC CHANGE:
The Unit Manager completed education on 10/12/23, for licensed nurses to ensure Digoxin is held for a pulse less than 60 beats per minute and that any Digoxin orders without hold parameters are clarified with the provider. Nursing staff that were not available for education will be educated upon return to work prior to accepting an assignment.
The DON or Unit Manager will audit all new admission orders within 24 hours to

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medication. Nurse #2 stated she should have clarified the order with the Physician's Assistant or Physician when the resident returned back to the facility from the hospital.

Review of the August 2023 MAR from 8/29/23 to 8/31/23 indicated the Digoxin 125 mcg was initialed as administered and there were no parameters of when to hold the medication included on the MAR.

Review of the September 2023 physician orders revealed an order dated 8/28/23 for Digoxin 125 mcg 1 tablet by mouth daily for atrial fibrillation. The parameters of when to hold the medication were not listed with the order.

The September 2023 MAR was reviewed from 9/1/23 through 9/26/23 and revealed the Digoxin 125 mcg was initialed as administered and there were no parameters of when to hold the medication included on the MAR.

The Director of Nursing was interviewed on 9/26/23 at 1:29 PM and reviewed the August 2023 and September 2023 MARs and orders. She stated Resident #73 was in the hospital from 8/21/23 to 8/28/23 and when she returned to the facility the transcribing nurse failed to put the parameters in the order. She felt this was an oversight.

The Physician's Assistant (PA) was interviewed on 9/27/23 at 9:58 AM and reviewed Resident #73's Digoxin orders from August 2023 and September 2023. He confirmed the pulse parameter of when to hold the medication was not transcribed when Resident #73 returned to the facility on 8/28/23 and would have expected a

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ensure appropriate medication parameters are in place and to protect residents in similar situations. This will be ongoing to ensure solutions are sustained.
4. HOW CORRECTIVE ACTION WILL BE MONITORED:
The Director of Nursing will complete all pharmacy recommendations within 72 hours to ensure that the problem does not reoccur.
The DON and Unit Manger will perform audits of residents on Digoxin 3 x week for 4 weeks and 2 x month for two months to monitor performance.
The DON or Unit Manager will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The DON or Unit Manager will review the plan during the monthly Quality Assurance Performance Improvement Meeting. The audits will continue at the discretion of the QAPI committee.

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F 757	Continued From page 28 pulse be taken prior to giving the medication. He further stated that he felt there was no serious harm caused as he monitored her Digoxin level lab work very closely.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/19/23

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F 758	Continued From page 29 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant, Physician's Assistant and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication (Resident #73). This was for 1 of 5 residents whose medications were reviewed. The findings included: Resident #73 was initially admitted to the facility on 5/31/23 with diagnoses that included dementia with psychotic disturbance, anxiety disorder, and depression. A review of Resident #73's medical record revealed she was hospitalized from 8/21/23 to 8/28/23. Per the hospital discharge summary dated 8/28/23, an order was present for Seroquel 25mg 1 tablet by mouth at bedtime 8:00 PM. A review of the active physician orders included an order dated 8/28/23 for Seroquel 25 mg 1 tab	F 758	All items listed on this self-imposed action plan have been completed and implemented on 10/18/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/2023. 1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Facility failed to provide adequate clinical indication for the use of an antipsychotic medication for resident #73. The resident had diagnosis of dementia, psychotic disturbance, anxiety disorder and depression. Resident #73 had an active order for Seroquel by mouth at bedtime for behaviors, which was not an approved diagnosis for this medication. On 9/27/23, the DON revised resident #73 order for Seroquel to include the correct diagnosis: Dementia with psychotic disturbance.	

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by mouth at bedtime for behaviors.

The September 2023 Medication Administration Record (MAR) indicated Resident #73 received Seroquel at bedtime as ordered.

A quarterly Minimum Data Set (MDS) assessment dated 9/7/23 indicated Resident #73 had moderately impaired cognition and received 7-days of an antipsychotic medication during the assessment period.

The Director of Nursing was interviewed on 9/26/23 at 1:29 PM and reviewed Resident #73's active physician orders. She confirmed the diagnosis for Seroquel use was behaviors and stated that was not an appropriate clinical indication.

On 9/26/23 at 1:47 PM, an interview occurred with Nurse #2 who was the readmitting nurse for Resident #73 on 8/28/23. She reviewed the order and stated she was unaware a diagnosis of behaviors was not an appropriate clinical indication for the use of Seroquel.

An interview occurred with the Physician's Assistant (PA) on 9/27/23 at 9:58 AM. He reviewed Resident #73's medical record and indicated when she returned from the hospital on 8/28/23 and the diagnosis of behaviors was chosen inadvertently. He was aware that a diagnosis of behaviors was not an appropriate clinical indication for the use of Seroquel and stated that the order should have been clarified at the time of readmission.

A phone interview was conducted with the consulting Pharmacist on 9/27/23 at 1:20 PM.

F 758

2. MEASURES TO IDENTIFY OTHER RESIDENTS AFFECTED:
Nursing leadership completed 100% audit of all current residents on Antipsychotic Medications to determine if they have an appropriate diagnosis for use. There were 3 residents that needed diagnosis updated under the order section of Point Click Care to reflect appropriate diagnosis for antipsychotic use. This was corrected by the Director of Nursing on 10/19/23.
3. MEASURES FOR SYSTEMIC CHANGE:
If a resident admits without a diagnosis for an antipsychotic medication, the provider is to be contacted for orders on how to proceed and for diagnosis.
The Director of Nursing and Unit Manager completed education on 10/19/23, for licensed nurses to ensure residents are not receiving antipsychotic medications without appropriate diagnosis. Nursing staff that were not available for education or newly hired will be educated upon return to work prior to accepting an assignment. The DON or Unit Manager will audit all new admission orders within 24 hours to ensure appropriate antipsychotic medication diagnosis is in place and to protect residents in similar situations. This will be ongoing to ensure solutions are sustained.
4. HOW CORRECTIVE ACTION WILL BE MONITORED:
The Director of Nursing will complete all pharmacy recommendations within 72 hours to ensure that the problem does not reoccur. The DON, ADON and Unit Manger will perform audits of residents on

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F 758	Continued From page 31 She was able to review her monthly drug regimen reviews for Resident #73 and stated that on 9/26/23 she requested for the facility to provide a qualifying diagnosis for the Seroquel that was used daily.	F 758	antipsychotics for appropriate diagnosis 3 x week for 4 weeks and 2 x month for two months to monitor performance. The DON or Unit Manager will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly Quality Assurance Performance Improvement Meeting. The audits will continue at the discretion of the QAPI committee.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Physician Assistant (PA) and Medical Director (MD), the facility failed to provide scheduled antianxiety medication resulting in multiple missed days of a significant medication for 1 of 5 (Resident #26) reviewed for unnecessary medications. The findings included: Resident #26 was admitted to the facility on 11/22/2019 with diagnoses that included major depressive disorder and psychosis and anxiety disorder. Resident # 26's quarterly Minimum Data Set (MDS) dated 9/6/2023 indicated the resident was moderately cognitively impaired and received	F 760	All items listed on this self-imposed action plan have been completed and implemented on 10/19/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/20/2023. 1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Facility failed to provide scheduled antianxiety medication resulting in multiple missed days of significant medication for resident #26. The Mental Health Nurse Practitioner made a recommendation to schedule Resident #26 Lorazepam, however due to failure in communication systems the recommendation was not viewed by the	10/20/23

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antipsychotics and antidepressants 7 out of 7 days during the assessment period.

Resident #26's medical record contained an after-visit summary by the Mental Health Nurse Practitioner dated 8/23/2023. The summary indicated the resident had been on 0.5mg of lorazepam as needed for anxiety for 14 days. Staff reported Resident #26 showed reduction in anxiety behaviors with the lorazepam. The Mental Health Nurse Practitioner recommended changing the lorazepam from as needed twice daily to scheduled twice daily with a start date of 8/24/20253.

Resident #26's August Medication Administration Record (MAR) indicated the resident received 0.5mg lorazepam every 12 hours as needed with a start date of 8/10/2023 and an end date of 8/24/2023. The resident did not receive lorazepam from 8/24/2023 through 8/29/2023. There was no active order for lorazepam during that time.

The resident's behavioral monitoring did not reveal any behaviors related to anxiety between 8/24/2023 and 8/29/2023.
Further review of the August MAR revealed the Medical Director (MD) wrote an order for lorazepam 0.5mg every 12 hours as needed for breakthrough anxiety was started on 8/30/2023 with an end date of 9/12/2023 due to staff reports of ongoing anxiety.

The September MAR indicated the resident received 0.5mg of lorazepam every 12 hours as needed for anxiety until 9/12/2023. The resident did not receive any lorazepam from 9/12/2023 through 9/24/2023 as there was no active order

F 760

facility Physician Assistant or Medical Director and the medication change was not made. The Director of Nursing verified that the visit summaries were being emailed to the previous Director of Nursing email and Medical Records. Medical Records was scanning them into resident files without the provider ever reviewing the visit summary or recommendations. There was no harm to Resident #26 due to the missed medication. Resident #26 is currently receiving medication as ordered.
2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED:
Nursing leadership completed an audit on 10/17/23 of all current residents who are seen by the Mental Health Services Provider in last 30 days to determine if any other medication orders / recommendations had been missed. Two residents were affected by this alleged practice and were unharmed by the missed recommendation.
3. MEASURES FOR SYSTEMIC CHANGE: The Director of Nursing contacted the Mental Health Services Provider and provided the correct list of email contacts to include the current DON, unit managers, Physician Assistant, Medical Director, Social worker, and Medical Records. The email contacts were updated by the outside provider and the list is now current and active. The DON completed education on 10/19/23, for Unit Manager, Physician Assistant, and Medical Director, Medical Records and Social Worker pertaining to the new process for printing, reviewing, signing,

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F 760	Continued From page 33 for lorazepam at that time. The MAR indicated 0.5mg of lorazepam scheduled every 12 hours started on 9/25/2023. The order was written by the Medical Director (MD). The resident's behavioral monitoring revealed on 9/16/2023 the resident was observed yelling and crying out that something was wrong with her hand. Staff calmed the resident and assured her hand was fine. Nonpharmacological interventions were effective. An interview was conducted with the Physician Assistant (PA) on 9/27/2023 at 10:08 AM. He stated he had not seen the recommendation to make Resident #26's lorazepam scheduled instead of as needed. He further stated the mental health nurse practitioner faxed her visit summaries to the facility and they are placed in the communication notebook for him and the Medical Director (MD) to review. He would have initialed and dated the after-visit summary if he had reviewed it. He stated the summary was uploaded into the medical record without being reviewed. On 9/27/2023 at 10:56 AM an interview was conducted with the Director of Nursing (DON). She stated the visit summaries are faxed to the facility and should be placed in the provider's communication notebook for them to acknowledge. However, the after-visit summary for Resident #26 did not have a date or initials so it had not been acknowledged by the providers. She did not know why the error had occurred. She stated they needed to work on the process to ensure the providers review the after-visit summaries before they are uploaded into the medical record.	F 760	and scanning of Behavioral Health Records. 4. HOW CORRECTIVE ACTION WILL BE MONITORED: The DON, Assistant Director of Nursing and Unit Manger will perform audits 3 x week for 4 weeks and 2 x month for two months to ensure providers are reviewing Behavioral Health Summaries prior to them being scanned into PCC. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly Quality Assurance Performance Improvement meeting. The audits will continue at the discretion of the QAPI committee.	

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F 760	Continued From page 34 On 9/27/2023 at 1:26 PM an interview was conducted with the MD. She stated she saw the recommendation when she reviewed the mental health providers after visit summaries as part of her regulatory visit on 9/25/2023. She had not seen the recommendation prior to that date. She further stated the after-visit summary should have been placed in the communication notebook for her or the PA to verify.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff, Dishwasher Repairman, and Regional Dietary Director, the facility failed to label opened food items stored in 1 of 1 walk in	F 812	All items listed on this self-imposed action plan has been completed and implemented on 10/18/23 with ongoing monitoring to ensure compliance. This	10/19/23

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coolers, 1 of 1 reach in coolers, and 1 of 1 walk in freezers and failed to maintain water temperature during the wash and rinse cycles of the high-temp dishwasher according to manufacturer ' s instructions for 3 of 4 observations. This practice had the potential to affect food served to residents.

Findings included:

1. During the initial tour of the kitchen on 09/25/23 at 09:18 AM in the presence of the Dietary Manager (DM) the following were observed:

a. Located in the reach-in refrigerator available for use was one ham and cheese sandwich without a label. The DM verified the sandwich did not contain a label and she discarded the item.

b. Located in the walk-in refrigerator available for use were two trays containing 64 single serving individual cups with a white substance with no label. The DM identified the white substance as sour cream and stated that it should have been labeled and dated when prepared.

On 09/25/23 at 09:24 AM an interview was conducted with Dietary Aide #3. She stated she prepared the cups of sour cream this morning (09/25/23) for today ' s lunch but forgot to label the cups/trays.

c. Located in the walk-in freezer available for use were the following items:

- One opened box of four ounce Pork Choppette patties that was 1/4 full and undated. The DM stated that the box should have been labeled with the date it was delivered to the facility.

F 812

concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/23.
1. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: The survey team observed that the facility allegedly failed to label and date open food items. It was also determined that the high temperature dish washing machine was not consistently maintaining required wash and rinse temperatures. The alleged deficiency did not affect one specific resident from the sample list.
2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENTS AFFECTED: All residents have the potential to be affected by this alleged deficient practice. In response to implementing an acceptable plan of correction for the alleged deficiency, the dietary manager in-serviced all dietary staff that it is their responsibility to ensure food is labeled upon delivery to the kitchen. This in-service will be complete by October 18, 2023. This in-service will be part of the orientation process for all newly hired dietary employees to maintain compliance. In response to the dish machine rinse cycle temperature being observed to be lower than the required temp. of 180 degrees and that the washing detergent container was empty, the dietary manager, administrator, regional dietary director, and maintenance director were notified. The administrator in-serviced all dietary staff at 10:15 on 9/25/23 regarding chemical supply par level. When one container of chemicals

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-One 30 pound (lb) opened box of cut corn that was 1/4 full, undated and unlabeled. The DM stated that the box should have been labeled with the date it was delivered to the facility.

-One 30 lb opened box of sliced zucchini that was 1/4 full, undated and unlabeled. The DM stated that the box should have been labeled with the date it was delivered to the facility.

-One 30 lb opened box of cut cauliflower that was 1/2 full, undated and unlabeled. The DM stated that the box should have been labeled with the date it was delivered to the facility.

-One 30 lb opened box of sweet peas that was 1/2 full, undated and unlabeled. The DM stated that the box should have been labeled with the date it was delivered to the facility.

On 09/25/23 at 9:31 AM an interview was conducted with the Dietary Manager (DM). She stated that it was everyone ' s responsibility for labeling food when it was delivered to the facility, opening and/or preparing the items. She stated per policy, all foods stored in the refrigerator or freezer were to be covered and dated. Received dates (dates of delivery) will be marked on cases. All prepared food in refrigerators should be labeled with the date the item was prepared and with the "Use by" (expiration) date.

2. During the initial tour of the kitchen on 09/25/23 at 9:46 AM in the presence of the Dietary Manager (DM), racks of dirty dishes were being run through the high temperature dish-machine by Dietary Aide #2. The high temperature dish-machine rinse temperature gauge read 140

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remains in the chemical storage area, staff is to report to the Dietary Manager and Administrator. The Dietary Manager will contact the supplier to get needed chemicals sent immediately. The Administrator will contact the Regional Director of Operations to locate back up chemical(s) at sister building to have delivered by the next business day.
3. MEASURES FOR SYSTEMIC CHANGE: The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains in compliance with the regulatory requirements will be that the administrator or dietary manager will audit 5 x per week x 4 weeks and then twice per week for two months to ensure open food and/or drinks are properly dated. This includes the date of when an item is prepared and the “Use by” date. This audit will be documented on the refrigerated storage area audit tool posted on the kitchen reach-in refrigerator and walk-in refrigerator/freezer. Education was provided on what chemicals are used for each function of the kitchen, where chemicals are stored when delivered and how they are installed for use. The Dietary Manager created a declining balance inventory sheet to be used in the chemical storage area. Dietary staff were also educated on immediate reporting of temperature issues and the need for heat booster resets. On 9/26/23, in response to the alleged deficiency, a low temp dish machine conversion was ordered. Upon conversion of the low-temp dish machine, all dietary staff, administrator &

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degrees Fahrenheit (F) and 145 degrees F during the wash cycle. Dietary Aide #1 was removing the racks of washed meal trays and putting them on a drying rack. The DM stated she thought the dishwasher was a low-temperature dish-machine and she checked the dish-machine temperature and chemical levels daily but had not checked them today. A container located on the wall with hoses connected to the dishwasher was empty. The DM stated the container was the washing detergent for the dishwasher and the shipment had not arrived yet. She reset the heat booster, ran empty racks through the dishwasher for 3 cycles and then used a temperature strip to check the temperature. The strip turned completely orange which indicated the water was at 180 degrees F. The DM implemented that washing/rinsing the dishes using the dishwasher was ceased until the wash detergent arrived at the facility. All lunch meals were served on disposable dinnerware with disposable silverware. The wash detergent arrived at approximately 2:00 PM.

On 09/25/23 at 9:52 AM an interview was conducted with Dietary Aide #2. He stated he did not check the water temperature with the temperature strip today. He stated that they have had problems with the heater booster and would have to reset it prior to washing the dishes. He indicated he had reset the heater booster, but he did not realize the temperature gauge read 140 degrees F during the rinse cycle. He was unsure what the manufacturer ' s temperature requirement was. He also stated he did not realize the detergent solution was empty.

On 09/25/23 at 9:52 AM an interview was conducted with Dietary Aide #1. He indicated he

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maintenance director will be in-serviced on proper operating procedures to include chemicals required.
4. HOW CORRECTIVE ACTION WILL BE MONITORED: The monthly quality assurance performance improvement (QAPI) committee will review the results of the audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and will make recommendations for monitoring for continued compliance. The administrator or dietary manager will present the findings and recommendations of the monthly QAPI committee to the quarterly QAPI committee for further recommendations and oversight.

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had not looked at the temperature gauge prior to washing the dishes today and was unsure what the manufacturer ' s temperature requirement was. He stated that they have had problems with the heater booster and would have to reset it prior to washing the dishes.

On 09/26/23 at 10:19 AM the Regional Dietary Director was interviewed. He stated the dishwasher was a high temp dishwasher. The rinse temperature of 140 degrees F, and wash temp of 145 degrees yesterday may have been caused by the booster heater tripping. After resetting the booster heater, the temps read within recommended guidelines. He supplied a service call report dated 09/25/23 at 2:38 PM. The service report revealed the overload tripped on booster heater, reset and made sure all temperatures were correct at that time.

A follow up kitchen observation was conducted on 09/26/23 at 1:24 PM. Dietary Aide #1 was observed running racks of dirty dishes through the high temperature dish-machine. A second observation at this time revealed the dish-machine temperature gauge read 135 degrees F during the rinse cycle. He stated he did not realize the temperature was at 135 degrees F.

On 09/26/23 at 1:25 PM an observation and interview were conducted with the Regional Dietary Director. He verified the temperature gauge read 135 degrees F during the rinse cycle. He immediately educated the dietary aides that they needed to reset the booster heater and to run empty trays through the dishwasher until the gauge read the correct temperature which was 180 degrees F for the finale rinse cycle and

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F 812	Continued From page 39 150-165 degrees F for the wash cycle. After the booster heater was reset, the dishwasher temperature gauge read 185 degrees F for the rinse cycle and 150 degrees F for the wash cycle. He also checked the water temperature which read 180 degrees F. The Regional Dietary Director had the Maintenance Director to call the Dishwasher Repairman to come back in to reevaluate the dishwasher. All dishes were rewashed when the appropriate temperatures were reached. On 09/27/23 at 12:47 PM through 1:05 PM an interview was conducted with the Dishwasher Repairman. He reset the booster heater and the temperature gauges went up to 185 degree F for the rinse cycle and 170 degree F for the resting wash temperature. He stated the temperature gauges were working correctly and that it seemed the heater booster was tripping causing the temperatures to drop during the wash/rinse cycle. The Dishwasher Repairman stated the staff needed to monitor the temperature gauges and reset the heater booster if the temperatures start to drop. A follow up kitchen observation was conducted on 09/27/23 at 12:59 PM. Dietary Aide #1 was observed running racks of dirty dishes through the high temperature dish-machine. The third observation revealed the dish-machine temperature gauge read 135 degrees F during the rinse cycle. He stated he did not realize the temperature was at 135 degrees F. The heater booster was reset, and the dishes were rewashed when the appropriate temperature was reached. On 09/27/23 at 1:05 PM an interview was conducted with the Maintenance Director. He	F 812		

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F 812	Continued From page 40 stated repairs to the heater booster were conducted on 08/24/23. All terminal connections were checked and tightened, and the power feed contactor was replaced. He indicated they have had problems with the heater booster for a while. On 09/27/23 at 1:22 PM, the Administrator was interviewed. She stated that she expected the Dietary Manager (DM) to inform her and the Maintenance Director immediately when the dish-machine was not working properly. The administrator stated her expectation was that dietary properly label all food items per policy in the coolers and the freezer.	F 812		
F 867 SS=F	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	F 867		10/19/23

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F 867	Continued From page 41 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that 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.	F 867		

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§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and 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

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F 867	Continued From page 43 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Pharmacy Consultant, Hospice Aide, Physician's Assistant, Wound Nurse Practitioner, Dishwasher Repairman, Regional Dietary Director, resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following an annual recertification and complaint survey on 9/20/21. This was for five deficiencies that were cited in the areas of Accuracy of Assessments, Treatment/Services to Prevent/Heal Pressure Ulcers, Free of Accident/Hazards/Supervision/Devices, Free from Unnecessary Psychotropic Medications, and Food Procurement/Store/Prepare/Serve-Sanitary. In addition, five additional deficiencies were cited during the annual recertification and complaint survey on 7/20/22 in the areas of Accuracy of Assessments, Treatment/Services to Prevent/Heal Pressure Ulcers, Increase/Prevent Decrease in Range of Motion/Mobility, Residents are Free of Significant Medication Errors and Food Procurement/Store/Prepare/Serve-Sanitary. The duplicate citations during three federal surveys of record show a pattern of the facility's	F 867	All items listed on this self-imposed action plan have been completed and implemented on 10/18/2023 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 10/19/2023. 1. HOW CRRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S): F758 - Facility failed to provide adequate clinical indication for the use of an antipsychotic medication for resident #73. The resident had diagnosis of dementia, psychotic disturbance, anxiety disorder and depression. Resident #73 had an active order for Seroquel by mouth at bedtime for behaviors, which was not an approved diagnosis for this medication. The DON corrected the diagnosis for this resident to reflect Dementia with psychotic behaviors on 9/27/23. F689 - Resident #68 sustained a fall on 7/27/23 when hospice aide positioned him on his side and stepped away from the bedside to retrieve a washcloth. This	

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inability to sustain an effective QAPI program.

The findings included:

The citations are cross referenced to:

1) F758- Based on record review and interviews with the Pharmacy Consultant, Physician's Assistant and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication (Resident #73). This was for 1 of 5 residents whose medications were reviewed.

During the facility's annual recertification and complaint survey dated 9/20/21, the facility failed to assess residents on antipsychotic medication for abnormal involuntary movement disorders, failed to identify target behavioral symptoms and to monitor those symptoms, failed to evaluate residents on psychotropic medications for gradual dose reductions and failed to ensure PRN (as needed) psychotropic medications were time limited in duration for 7 of 9 residents whose medications were reviewed.

An interview was completed with the Administrator and DON on 9/28/23 at 10:30 AM and felt it was an oversight not to have an appropriate clinical indication for the use of a psychotropic medication.

2) F689- Based on staff and Hospice Aide #1 interviews along with record review, the facility failed to provide care safely which resulted in a fall without injury when Hospice Aide #1 left Resident #68's on his side in bed to retrieve a washcloth and failed to ensure two staff were

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resulted in a fall with no injury. Resident required two staff members for bed mobility however hospice aide did not have a second staff member present during care. No harm was caused to Resident #68 due to the incident.
F686 - Residents #178 no longer resides in the facility.
F812 - The survey team observed that the facility failed to label and date open food items. It was also determined that the high temperature dish washing machine was not consistently maintaining required wash and rinse temperatures which required immediate repair or use of paper serving products.
F641 Resident #6 was found to have inaccurate coding of bathing on 7/22/23 and was corrected and coded accurately on the minimum data set by the Minimum Data Set Coordinator on 9/28/23.
F688 The facility failed to apply left lower extremity (LLE) brace as ordered to resident #44. The resident was ordered to wear knee brace to LLE for 4 hours a day or as tolerated, while lying supine in bed for contracture management. Resident # 44 has had order added to eTAR for nurses to sign off on donning and doffing of brace as ordered. Resident # 44 is currently having brace applied per order.
F760 - Facility failed to provide scheduled antianxiety medication resulting in multiple missed days of significant medication for Resident #26. The Mental Health NP made a recommendation to schedule resident #26 Lorazepam, however due to failure in communication systems the recommendation was not viewed by the

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presence for bed mobility. This was for 1 (Resident #68) of 8 reviewed for accidents.
During the facility's annual recertification and complaint survey dated 9/20/21, the facility failed to implement a fall intervention for a resident who sustained a fall with the staff present for 1 of 3 residents reviewed for accidents.

On 9/28/23 at 10:30 AM, an interview occurred with the Administrator and DON. They both indicated that education was needed for both staff and Hospice providers. A meeting was going to be held with the Hospice providers.

3) F686- Based on record reviews and interviews with staff, Physician Assistant (PA), Wound Nurse Practitioner, and Medical Director (MD), the facility failed to implement preventative measures for a resident assessed to be moderate to high risk for development of pressure ulcers. The resident developed a deep tissue injury to the sacrum, 2 deep tissue injuries to the left lateral foot, as well as a deep tissue injury to the left ankle. Deterioration of the sacral wound was not communicated to the MD or the PA. The resident was admitted to the hospital with septic shock for 1 of 8 residents (Resident #178) reviewed for pressure injuries.
During the facility's annual recertification and complaint survey dated 9/20/21, the facility failed to obtain a treatment order when pressure ulcers were first identified for 1 of 4 residents reviewed for pressure ulcers.

During the facility's annual recertification and complaint survey dated 7/20/22, the facility failed to complete pressure ulcer treatments as ordered and failed to provide a specialized wheelchair

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facility Physician Assistant or Medical Director and the medication change was not made. The DON verified that the visit summaries were being emailed to the previous Director of Nursing email and Medical Records. Medical Records was scanning them into resident files without the provider ever reviewing the visit summary or recommendations. Resident #26 is currently receiving medication as ordered. There was no harm to resident #26 due to the missed medication.

2. MEASURES TAKEN TO IDENTIFY OTHER RESIDENT AFFECTED:
F758 DON will continue to respond to recommendations based on pharmacy new admission and monthly drug regimen reviews. If a resident admits without a diagnosis for an antipsychotic medication, the provider should be contacted for orders on how to proceed and for diagnosis. The DON and Unit Manager completed education on 10/19/23, for licensed nurses to ensure residents are not receiving antipsychotic medications without appropriate diagnosis. Nursing staff that were not available for education or newly hired will be educated upon return to work prior to accepting an assignment.
F686 - All residents with wounds are at risk, nursing management completed a 100% audit of all current residents with wounds on 10/18/23 to ensure that Physician had been notified of current wound status, and that appropriate interventions were in place to prevent further deterioration of wounds.

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cushion as ordered for 3 of 5 residents reviewed for pressure ulcer care.

In an interview with the Administrator and Director of Nursing (DON) on 9/28/23 at 10:30 AM, they indicated there had been turn over with wound care staff as well as wound care providers in the last year. Unit Managers were now responsible for wound care on their units.

4) F812- Based on record review, observations and interviews with staff, Dishwasher Repairman, and Regional Dietary Director, the facility failed to label opened food items stored in 1 of 1 walk in coolers, 1 of 1 reach in coolers, and 1 of 1 walk in freezers and failed to maintain water temperature during the wash and rinse cycles of the high-temp dishwasher according to manufacturer's instructions for 3 of 4 observations. This practice had the potential to affect food served to residents.
During the facility's annual recertification and complaint survey dated 9/20/21, the facility failed to label and date food items in a container after opening, failed to date thawed nutritional supplements, and failed to wear hair and beard restraints for 2 of 2 kitchen observations.

During the facility's annual recertification and complaint survey dated 7/20/22, the facility failed to ensure food items in the walk-in cooler, that had been opened were labeled and dated for 1 of 1 walk in coolers.

During an interview with the Administrator and DON on 9/28/23 at 10:30 AM, they indicated there had been a lot of transition in the kitchen with new staff to include the dietary manager.

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F689 The hospice aide received education from both her supervisor and facility DON regarding not leaving resident unattended on their side and having 2 staff members present when turning and repositioning. The residents care plan was revised by DON to reflect two person assist with turning and repositioning in bed.
F812 - All residents have the potential to be affected by this alleged deficient practice. In response to implementing an acceptable plan of correction for the deficiency cited on Sept. 25, 2023, the dietary manager in-serviced all dietary staff that it is their responsibility to ensure food is labeled upon delivery to the kitchen. This in-service will be complete by October 18, 2023. This in-service will be part of the orientation process for all newly hired dietary employees to maintain compliance. The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains in compliance with the regulatory requirements will be that the administrator, dietary manager, or cook will audit twice weekly x 12 weeks to ensure open food and/or drinks are properly dated. This includes the date of when an item is prepared and the Use by date. This audit will be documented on the refrigerated storage area audit tool posted on the kitchen reach-in refrigerator and walk-in refrigerator/freezer.
F641 - A focused review was completed by the Minimum Data Set Coordinator on 9/28/23 regarding the accuracy of coding on the minimum data set in accordance

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Duty assignments were going to be put into place for dietary aides. The booster seemed to be an issue on the dishwasher and was going to be replaced with a low temperature dishwasher in two weeks.

5) F641- Based on record reviews, resident and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of bathing for 1 of 20 residents reviewed.

During the facility's annual recertification and complaint survey dated 9/20/21, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications, urinary catheter, weight loss, skin condition, and smoking for 8 of 20 residents reviewed.

During the facility's annual recertification and complaint survey dated 7/20/22, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of alarms, Hospice, and falls. This was for 3 of 19 resident records reviewed.

An interview occurred with the Administrator and DON on 9/28/23 at 10:30 AM and indicated they felt the repeat citations in MDS accuracy were related to human error as well as turnover in staff.

6) F688- Based on observations, resident and staff interviews, and record review, the facility failed to apply a left lower extremity (LLE) brace as ordered. This was for 1 (Resident #44) of 1 resident reviewed for range of motion (ROM). During the facility's annual recertification and

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with the resident assessment instruments for all residents over the past 3 months for bathing coding. Focused review revealed no other bathing coding discrepancies. This focused review was subsequently audited by the Director of Nursing on 10/18/23 and verified to be accurate.
F688 - The DON updated all current orders of residents with braces/splinting devices to include a schedule for the nurse to document application of the brace/splint on the MAR. If the resident refuses and splint device isnt applied, a progress note will populate for the nurse to complete.
F760 - Nursing leadership completed an audit of all current residents who were seen by the Mental Health Services Provider in the last 30 days to ensure all recommendations were reviewed by the facility PA/MD.

3. MEASURES FOR SYSTEMIC CHANGE:
F758 - DON will continue to respond to recommendations based on pharmacy new admission and monthly drug regimen reviews. If a resident admits without a diagnosis for an antipsychotic medication, the provider should be contacted for orders on how to proceed and for diagnosis. The DON, ADON and Unit manager completed education on 10/19/23, for licensed nurses to ensure residents are not receiving antipsychotic medications without appropriate diagnosis. Nursing staff that were not available for education or are newly hired will be educated upon return to work prior

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F 867	Continued From page 48 complaint survey dated 7/20/22, the facility failed to follow and implement Physician orders for a left resting hand splint for 1 of 1 resident reviewed for range of motion. During an interview with the Administrator and DON on 9/28/23 at 10:30 AM, they indicated there needed to be a process for when a resident was discharged from therapy services and the need for splint application. 7) F760- Based on record review and interviews with staff, Physician Assistant (PA) and Medical Director (MD), the facility failed to provide scheduled antianxiety medication resulting in multiple missed days of a significant medication for 1 of 5 (Resident #26) reviewed for unnecessary medications. During the facility's annual recertification and complaint survey dated 7/20/22, the facility failed to administer the Keppra (an antiseizure medication) to a resident as ordered from the hospital. This was for 1 of 4 sampled residents who were admitted/readmitted and were reviewed for medication errors. In an interview with the Administrator and Director of Nursing on 9/28/23 at 10:30 AM, they indicated that agency nursing ceased at the facility beginning of July 2023. They felt the use of agency staff could have contributed to this repeat citation.	F 867	to accepting an assignment. F689 - The DON, ADON and Unit manager completed education on 10/19/23, for licensed nurses and nursing aides. The Kardex is to be used as a reference to ensure staff are utilizing correct assistance with bed mobility and turning and repositioning. Staff are never to leave a resident unattended on their side while in bed. Nursing staff that were not available for education or newly hired will be educated upon return to work prior to accepting an assignment. F686 - All residents with wounds are at risk, nursing management completed a 100% audit of all current residents with wounds on 10/18/23 to ensure that Physician had been notified of current wound status, and that appropriate interventions were in place to prevent further deterioration of wounds. Education provided to the Wound Nurse Practitioner by the Director of Nursing regarding notification of new wounds and deterioration of wounds to the providers and the dietician. Education provided to all licensed nurses on Wound Care prevention and treatment to include interventions to prevent the development of wounds and the deterioration of wounds. F812 In response to the dish machine rinse cycle temperature being observed to be lower than the required temp. of 180 degrees and that the washing detergent container was empty, the dietary manager, administrator, regional dietary director, and maintenance director were notified. The administrator in-serviced all	

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F 867	Continued From page 49	F 867	dietary staff at 10:15 on 9/25/23 regarding chemical supply par level. When one container of chemicals remains in the chemical storage area, staff is to report to the Dietary Manager and Administrator. The Dietary Manager will contact EcoLab & SourceTech to get needed chemicals sent immediately. The Administrator will contact RDO to locate back up chemical(s) at sister building to have delivered by the next business day. Education was provided on what chemicals are used for each function of the kitchen, where chemicals are stored when delivered and how they are installed for use. The Dietary Manager created a declining balance inventory sheet to be used in the chemical storage area. Dietary staff were also educated on immediate reporting of temperature issues and the need for heat booster resets. On 9/26/23, in response to the alleged deficiency, a low temp dish machine was ordered and is to be installed as soon as it arrives. Upon installation of the low-temp dish machine, all dietary staff, administrator & maintenance director will be in-serviced on proper operating procedures to include chemicals required. F641 - A focused review was completed by the Minimum Data Set Coordinator on 9/28/23 regarding the accuracy of coding on the minimum data set in accordance with the resident assessment instruments for all residents over the past 3 months for bathing coding. Focused review revealed no other bathing coding discrepancies. This focused review was subsequently audited by the Director of Nursing on	

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F 867	Continued From page 50	F 867	10/18/23 and verified to be accurate. To protect residents from similar occurrences, the DON provided re-education to the Minimum Data Set Coordinators regarding the need for accurate coding on the minimum data set to reflect accurate coding for bathing. F688 - Therapy was advised to notify Nursing Management when a resident discharges from therapy services with orders for a brace/splint so that order accuracy can be confirmed in Point Click Care. The DON, and Unit Manager provided education for licensed nurses and CNAs regarding process for ensuring that braces and splinting devices are in place as ordered and documentation reflects application as well as refusals. Nursing staff that were not available for education or newly hired will be educated upon return to work prior to accepting an assignment. F760 - The DON contacted the Mental Health Services Provider and provided the correct list of email contacts to include the current DON, unit managers, PA, MD, Social Worker, and Medical Records. The email contacts were updated by the outside provider and the list is now current and active. The DON, ADON and Unit manager completed education on 10/19/23, for Unit Managers, Physician Assistant, and Medical Director, Medical Records and Social Worker pertaining to the new process for printing, reviewing, signing, and scanning of Behavioral Health Records. 4. HOW CORRECTIVE ACTION WILL BE	

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F 867	Continued From page 51	F 867	MONITORED: F758 - The DON, ADON, Unit manager will audit all new admission orders within 24 hours to ensure appropriate diagnoses are in place for antipsychotic medications. The DON and Unit Manger will perform audits 3 x week for 4 weeks and 2 x month for two months. The DON or Unit Manager will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or Unit Manager will review the plan during the monthly Quality Assurance Performance Improvement Meeting. The audits will continue at the discretion of the QAPI committee. F689 - The DON, ADON, Unit manager will perform random room audits 3 x week for 4 weeks, then 3 x week for two months to observe bed mobility. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI Meeting. The audits will continue at the discretion of the QAPI committee. F686 - Wound Nurse Practitioner to provide a written weekly update to Director of Nursing, Medical Providers and Registered Dietitian for all wounds. Director of Nursing to audit all wounds weekly in At Risk Meeting to ensure that interventions are in place as indicated. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee	

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F 867	Continued From page 52	F 867	responsible for ongoing compliance. F812 - The monthly quality assurance performance improvement (QAPI) committee will review the results of the audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and will make recommendations for monitoring for continued compliance. The administrator or dietary manager will present the findings and recommendations of the monthly QAPI committee to the quarterly executive QA committee for further recommendations and oversight. F641 - An audit sheet will be used by the DON or designee to monitor and ensure that all bathing was coded accurately on the MDS. This monitoring process will take place 2 x per week for 4 weeks, then monthly for two months. Any issues during monitoring will be addressed immediately. The Administrator or DON will report findings of the monitoring process to the facility QAPI Meeting for three months and will determine if any additional monitoring or modification of this plan is necessary to maintain compliance. F688 - The DON, ADON, Unit manager will perform order audits for all residents discharged from therapy with splints/braces within 24 hours. The DON or Unit Manager will perform random audits of resident orders with splints/braces 3 x per week for 4 weeks, then 2 x per week for two months. The DON or Unit Manager will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to	

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F 867	Continued From page 53	F 867	maintain compliance. The DON or Unit Manager will review the plan during the monthly QAPI Meeting, and the audits will continue at the discretion of the QAPI committee. F760 - The DON and Unit Manger will perform audits 3 x week for 4 weeks and 2 x month for two months to ensure providers are reviewing Behavioral Health Summaries prior to them being scanned into PCC. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	