STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING ______ B. WING ______	C 10/26/2023

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EMERALD RIDGE REHAB AND CARE CENTER	**25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804**

(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
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/23/23 through 10/26/23. Event ID# ZGE011. The following intakes were investigated NC00208832, NC00205970, NC00202937, NC00202540, NC00202262, NC00198516, NC00198281, NC00198211, NC00198182, NC00198147, NC00197018, NC00196233 and NC00194712. 5 of the 39 complaint allegations resulted in deficiency. On 11/15/23 the 2567 was amended to reflect changes as result of IDR. The EP039 tag was removed.	F 000		
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	F 552		11/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 11/17/2023

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 552	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, Responsible Party (RP) interview, Psychiatric Nurse Practitioner interview, staff and physician interviews, the facility failed to communicate and provide information in a language the resident could understand for a resident that did not speak or understand the English language for 1 of 1 resident reviewed for communication (Resident #43). The findings included: Resident #43 was admitted to the facility on 6/15/23 with diagnoses which included social pragmatic communication disorder (persistent difficulty with verbal and nonverbal communication) and altered mental status. The care plan initiated on 6/22/23 revealed Resident #43 was at risk for social isolation related to cognitive impairment and language barrier, speaks Romanian with interventions which included provide one on one activities as needed to prevent social isolation and to use communication board as needed. A care plan was initiated on 7/04/23 for communication problem related to impaired ability to make herself understood, speaks Romanian with interventions which included may call RP #1 for interpretation assistance when needed, communication cards with basic needs, and to use simple consistent words/cues. Review of the Minimum Data Set (MDS) quarterly assessment dated 10/05/23 revealed Resident #43 was not assessed for cognition related to being rarely or never understood. Resident #43	F 552	Resident #43 will be reassessed by the IDT team using the Language Line as it relates to her cognition. Resident 43's Care plan will be updated on any cognitive differences, improvement or decline by 11/21/2023. Residents whose primary language is other than English as well as those needing interpreter services will be informed about the benefits of the Language Line upon admission. An informational page will be available in the admissions packet on 11/21/2023. The Executive Director in-serviced the staff on 11/09-11/15/2023 on the benefits and proper use of the language line. Education will be completed by 11/19/2023. Posters informing staff about the Language Line will be posted at the Nursing Station and Employee timeclock. The Medical Director, Extenders and Power Back Therapy staff were educated on 11/21/2023 regarding the Language Line available for use, as well as the expectation that the Language Line be used to interact with any Resident who needs the translation/Interpreter Services. The education packet is included in the staff in-service education book and will be be included in the orientation program for new hires.The DON/Designee will monitor the employees use of the Language Line during care plans, assessments and other pertinent medical evaluations by being present, with permission from the	

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was coded for her preferred language of Romanian and a need or want for an interpreter to communicate with a doctor or health care staff.

An interview was conducted on 10/23/23 at 1:21 pm with Nurse Aide (NA) #2 who was assigned to Resident #43 revealed Resident #43 did not speak or understand the English language. NA #2 stated she was told Resident #43 spoke Romanian. NA #2 stated she did not use communication boards with Resident #43 because she did not understand them. She stated she just tried different things to try to determine what Resident #43 may need when she completed her rounds. NA #2 stated the facility did not have a language line service to attempt to communicate with Resident #43.

During an observation and attempted interview on 10/23/23 at 2:27 pm Resident #43 was unable to communicate due to language barriers. No communication cards were observed near Resident #43.

Multiple attempts to interview Resident #43's Responsible Party (RP) #1 who was listed as the person to call for interpretation assistance on 10/23/23 at 2:25 pm, 10/24/23 at 8:55 am, and 10/25/23 at 12:30 pm were unsuccessful. RP #1's voicemail inbox was full, and no message was able to be left.

A telephone interview was conducted on 10/24/23 at 9:10 am with Resident #43's RP #2. RP #2 stated the facility was to call RP #1 for interpretation services and updates and RP #1 would contact the rest of the family and update them. RP #2 stated Resident #43 did not speak or understand English and confirmed she spoke

Resident. The monitors/observations will occur as needed 5X per week for 4 weeks and the 1X per week for two months.

The DON will present the monitoring plan to the QAPI team on 11/17/2023. QAPI Committee will review evaluations completed using the Language Line each month and make any recommendations for the monitor. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver.

Date of alleged compliance 11/22/2023

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only the Romanian language.

An interview was conducted on 10/24/23 at 9:21 am with NA #3 who was assigned to Resident #43. NA #3 stated the communication cards were in Resident #43's bedside table drawer and she could point to the picture that was what she needed but NA #3 stated Resident #43 did not seem to understand the pictures or words so most staff did not use them. NA #3 stated some of the staff have tried to use a free translation mobile application (app), but she stated she had not been successful using the free translation mobile app.

During an interview on 10/24/23 at 3:00 pm with Nurse #1 who was assigned to Resident #43 revealed he was unable to verbally communicate with Resident #43 and the free translation app did not work for her. Nurse #1 stated the facility did not have a language line or other interpretation services to use for Resident #43. Nurse #1 stated it was hard to contact Resident #43's RP via phone. He stated he was unable to review her medications with her but stated Resident #43 seemed familiar with the routine and seemed to know what he was doing.

An interview with the Speech Therapist (ST) was conducted on 10/24/23 at 11:36 am who revealed she had worked with Resident #43 upon admission to attempt to determine her cognition level and help staff to communicate with her. The ST stated Resident #43's RP #1 was listed to use for interpretation needs but she was not able to reach RP #1 when she tried to call for assistance and she was unable to leave a message for return call because the mailbox was full. The ST stated she looked up Romanian words and

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created a picture board of basic needs for staff to utilize but the ST was not sure if Resident #43 understood them. The ST reported she notified the Administrator, Social Worker, and the Director of Rehabilitation regarding the concern of Resident #43's communication needs but was told no one spoke Romanian. The ST stated she terminated the speech services because she was not able to determine how to effectively communicate with Resident #43 and did not feel she could ethically continue the service.

A telephone interview was conducted on 10/25/23 at 11:10 am with the Rehabilitation Director who revealed he was aware of the difficulty of communicating with Resident #43 and he stated there was difficulty to reach Resident #43's RP #1 for assistance with interpreter needs. He stated the Speech Therapist used all the resources available to her to determine how to best communicate with Resident #43, but they were not sure if she was able to understand. The Rehabilitation Director stated he discussed the ST concerns with the DON, and he stated he was not aware of the outcome but stated he was not aware the language line was available to attempt to communicate with Resident #43.

An interview was conducted on 10/24/23 at 1:24 pm with the Activities Director who revealed she was unable to verbally communicate with Resident #43, but she used hand gestures. The Activities Director stated she provides music, in room coloring activity, and group functions for Resident #43 to improve her social interaction.

An interview was conducted on 10/24/23 at 12:17 pm with the Social Worker who revealed Resident #43's RP #1 assisted with the cognition

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F 552	Continued From page 5 questions of the admission assessment via a telephone interview, and he had not needed to contact Resident #43's RP #1 since the initial interview. The Social Worker stated he tried the free translation app and was not able to communicate with Resident #43. He stated he did not recall the ST reporting she was unable to continue services due to inability to communicate with Resident #43. He stated he had not attempted to use the communication board with Resident #43 because he had not had to communicate with her at this time. The Social Worker reported the facility did not have a language line to use for translation services and there was not a local translation service they were able to use. An interview was conducted on 10/24/23 at 11:43 am with the Psychiatric Nurse Practitioner (NP) who revealed she was assigned to provide services to Resident #43, but she was unable to communicate with her. The Psychiatric NP stated she spoke with staff and no behaviors were reported and Resident #43 appeared to be pleasant during her observations. The Psychiatric NP stated she attempted to use the free translation app and had a colleague attempt to translate for Resident #43, but the attempts were unsuccessful. During an interview on 10/24/23 at 1:24 pm with Nurse Practitioner (NP) #1, she revealed she was unable to communicate effectively with Resident #43 regarding her care. NP #1 stated she pointed to areas of the body, but she was not able to say that Resident #43 understood what was being asked. NP #1 stated Resident #43 could not understand what she was trying to say, and NP #1 could not understand what Resident #43	F 552		

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was saying. NP #1 stated she had attempted to use the free translation app, but it was not successful, and she was unable to reach Resident #43's RP #1 for assistance. NP #1 stated she had discussed her concern with the Director of Nursing (DON) on multiple occasions and was told by the DON that the facility did not provide translation services. NP #1 stated she did not speak to the Administrator regarding the need for translation services for Resident #43 because she was following the chain of command by going to the DON for nursing concerns.

A telephone interview was conducted on 10/26/23 at 1:45 pm with the Medical Director who revealed he was not aware of the communication concern regarding Resident #43. He stated he was not sure of her mentation potential but stated her inability to communicate with the staff and providers did not pose a concern because they provided care to residents that are unable to speak for other reasons and are still able to provide the care needed.

An interview was conducted on 10/24/23 at 3:09 pm with the DON who revealed she did not recall NP #1 or the therapy department reporting a concern regarding communication needs for Resident #43. She stated Resident #43's RP #1 was listed for interpreter needs and she was aware of the difficulty to make phone contact with her. The DON stated the facility did not provide a language line service or other forms of interpreter services, but the staff were able to use the free translation app on their personal phones or the communication board for Resident #43. The DON stated she did not discuss the use of a language line or other interpreter services with the Administrator or her corporate office for

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F 552	Continued From page 7 Resident #43. An interview was conducted with the Regional Clinical Director on 10/24/23 at 3:30 pm who revealed the facility did have a language line service that was available for all staff to communicate with Resident #43. An interview was conducted with the Administrator on 10/25/23 at 2:15 pm who revealed she was not made aware of the communication concerns for Resident #43 because it had not been brought to her attention. The Administrator stated the facility had the language line services available for any resident that required the services.	F 552		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		11/22/23

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F 565	Continued From page 8 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to resolve repeat concerns regarding cold food temperatures and late meal delivery reported during the Resident Council meetings for 10 of 13 months (October 2022, November 2022, December 2022, January 2023, Feburary 2023, March 2023, May 2023, June 2023, July 2023, and October 2023) months reviewed. Findings included: Record review of October 2022 Resident Council meeting revealed concerns related to delayed laundry and late meal delivery were presented. Record review of November 2022 Resident Council meeting revealed concerns related to late meal delivery and laundry delayed. The minutes revealed there was no response from the facility about late meal delivery and delayed laundry from October 2022 resident council meeting minutes.	F 565	Resident Council along with the Resident Council President will be informed by the Executive Director of the policy and procedure related to grievances expressed during Resident Council and the 14-day response time for follow up on any outstanding and recurring issues on 11/14/23. The Executive Director requested permission from the Resident Council President to attend all upcoming Resident Council meetings. The Executive Director and Activity Director will both take minutes to ensure accurate reporting of grievances. The Activity Director and Assistant will be in-serviced by the Executive Director on the policy and procedure on Resident Council Minutes as well as the Grievance policy to ensure any other Residents not attending the Resident Council will be informed of the policy. Resident Council	

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F 565	Continued From page 9 Record review of December 2022 Resident Council meeting revealed concerns related to meals not being consistent and late meal delivery. The Administrator was present at the December 2022 meeting. She spoke about housekeeping and dietary staffing challenges. Record review of January 2023 Resident Council meeting minutes revealed concerns related to dietary issues, cold food, not enough variety of food, and residents receiving things on dislike list. There was no response from the facility about late meal delivery concerns from December 2022 meeting. Record review of February 2023 Resident Council meeting minutes revealed concerns related to poorly cooked food, and laundry not coming back timely, Record review of March 2023 Resident Council meeting revealed concerns related to cold food, not enough variety, not timely, and meal tickets not followed. The Director of Nursing was present during the March 2023 meeting and there was no response from the facility from the resident council minutes of February 2023. Record review of April 2023 Resident Council meeting revealed concerns related to laundry delay and housekeeping getting worse. Record review of May 2023 Resident Council meeting revealed concerns related to food quality, timeliness of meal delivery, and housekeeping issues of delayed laundry. Record review of June 2023 Resident Council	F 565	minutes are published and available to all Residents. Respective Department Heads upon invitation by the Resident Council will address any departmental issues each month at Resident Council that may adversely affecting the Residents and be required to follow up with the Resident Council within 14 days of Resident Council Notification. The Resident Council minutes will be reviewed by the Executive Director each month for 6 months to ensure expressed grievances are remedied within the 14-day time frame. Resident Council Minutes and grievances will be reviewed by the QAPI Team monthly for 12 months to ensure timely resolution of grievance and to make any recommendations for the monitor. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver.	

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F 565	Continued From page 10 meeting revealed concerns related to delayed and inconsistent tray times and laundry sent to the wrong residents. The Administrator was present for the June 2023 meeting and spoke about hiring more people for all positions. Record review of July 2023 Resident Council meeting minutes revealed concerns related to housekeeping issues (Clothes mix up), quality of meals, cold food and portion sizes. The minutes revealed the facility responded to the June 2023 meeting minutes and stated the facility still had staff shortages. Record review of August 2023 Resident Council meeting minutes revealed no response from the facility about housekeeping problems, quality of food and portion sizes from July 2023 meeting. Record review of September 2023 Resident Council meeting minutes revealed there was no meeting held due to COVID restrictions. Record review of October 2023 Resident Council meeting minutes revealed concerns related to delivery of meals while cold and call bell not being accessible. The minutes revealed no response from the facility about cold food temperatures concerns from July 2023 meeting. During an interview on 10/23/2023 at 9:25 A.M. Resident #37 revealed meal trays arrive late most of the time. Resident #37 revealed one day a week ago dinner meal trays arrived at 7:00 P.M. In an interview on 10/23/2023 at 9:52 AM Resident #148 revealed meal trays arrive late most of the time. Resident #148 stated he never knew what time to expect a meal and that lunch	F 565		

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F 565	Continued From page 11 would come as late as 2:00 pm on some days. A Resident Council meeting was held on 10/25/2023 at 11:25 A.M. with nine alert and oriented residents who attended the Resident Council meetings regularly. All the residents in attendance reported the concerns with late meal delivery, cold food temperatures, laundry delay and mix up was ongoing and had not improved. During an interview with the District Dietary manager on 10/24/2023 at 9:25 A.M. she revealed meal delivery is improving but they are still struggling with hiring enough kitchen staff to ensure meal carts go out on time. During an interview on 10/26/2023 at 2:25 P.M. the Director of Nursing (DON) revealed she was frustrated by the contracted dietary company and has contacted them severally about food quality and delivery of meals timely. During an interview on 10/23/2023 at 3:06 P.M. the Administrator revealed she was aware of the concerns related to late meals and housekeeping in Resident Council. She stated she was addressing the concerns. She stated there has been constant turnover with the contracted kitchen staff. She revealed it was a systemic problem and she had exhausted everything in addressing the issues.	F 565		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with	F 577		11/22/23

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EMERALD RIDGE REHAB AND CARE CENTER	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

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F 577	Continued From page 12 respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, Facility failed to inform residents (Residents #52, #47, #2, #49, #40, #150, #76, #17, and #21) of the location of the most recent survey results and failed to display the survey results in a location accessible to residents. Findings: During an initial tour of the building on 10/23/2023 at 11:09 A.M. survey results were unable to be located. No signage was observed posted regarding the availability and location of survey results. A Resident Council meeting was conducted on	F 577	On 11/15/23 Residents #52, #47, #2, #49, #40, #150, #76, #17 and #21 will be informed of where the survey results are located and where the signage is directing them to the stated location by the Executive Director/designee. In addition, staff will be informed of where the most recent survey(s) and plans of correction are located. Newly admitted residents will be informed on admission via a notification in the admission packet as to where the survey results and plans of correction are located. Current residents attending were informed via monthly Resident Council meeting	

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F 577	Continued From page 13 10/25/2023 at 11:25 A.M. During the meeting 9 of 9 residents, (Residents #52, #47, #2, #49, #40, #150, #76, #17, and #21) stated they did not know where the survey results were located and had not seen any signage that directed residents to the location. Residents #21, and #76 stated they wished to review the state survey results binder but did not know its location. During an interview with the Activities Director on 10/25/2023 at 12:08 P.M. She stated she did not know where the state survey results were located. In an interview with the Director of Nursing (DON) 10/25/2023 at 1:55 P.M. she stated the survey binder was usually located at the main lobby/nursing station on the counter but was not aware of its current location. During an interview and observation conducted with the Administrator on 10/25/2023 at 2:25 P.M she stated the survey inspection results binder was moved during the remodeling of the wall towards the main lobby. She stated she placed the binder at the nursing station desk. She revealed she was responsible for the binder. She indicated she found out the binder went home with a family member and prepared a new survey inspection binder on 10/25/2023 at 3:39 P.M.	F 577	where the survey results are posted as well as the signage information regarding where the results are located. This information will be shared during Resident Council under 'Old Business' in the minutes for 3 months, and then annually thereafter. Visualization of the survey results will be recorded 5X/week for 2 weeks and monthly for 3 months. The Resident Council minutes and survey placement monitoring tool will be presented to the QAPI team monthly; based on results of the monitor, the QAPI team will make any necessary recommendations. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 602		11/22/23

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F 602	Continued From page 14 any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, resident, and Physician interviews the facility failed to protect a resident's right to be free of misappropriation of narcotic pain medication for 2 of 3 residents (Resident #27 & #247) reviewed for misappropriation of property. The findings included: a. Resident #27 was admitted to the facility on 2/15/22 with diagnoses that included a history of a left knee fracture and osteoarthritis. A review of Resident #27's Controlled Medication Utilization Record initiated on 6/29/23 revealed 4 medication cards containing 30 pills of Oxycodone 10mg were received from the pharmacy. A quarterly Minimum Data Set (MDS) assessment dated 7/3/23 revealed Resident #27 was moderately cognitively impaired, required limited assistance from 1 staff member to complete activities of daily living, and was not coded as requiring pain medication. A review of Resident #27's July 2023 Physician's orders revealed an order for Oxycodone 10 milligram (mg) 1 tablet by mouth 4 times daily that was discontinued by the Physician on 7/3/23. An interview was completed on 10/24/23 at 11:00am with Resident #27. She stated she had no pain at that time. b. Resident #247 was admitted to the facility on 2/11/20. The Resident's diagnoses included chronic pain and end stage renal failure.	F 602	Resident #27 and #247 suffered no adverse effects as the oxycodone was discontinued due to residents not needing the drug for pain. To protect other Residents,the DON/Designee in-serviced the nurses on 11/09/2023, regarding the protocol for performing a shift change narcotic count and that the incoming shift should not accept the medication cart keys if the count is incorrect. The DON/Designee is to be contacted immediately if the narcotic count is incorrect. Comprehensive investigations and action plans shall include but not be limited to inservicing of agency and new hires prior to working their first scheduled shift, how the appropriate staff conducts a controlled medication count at the beginning and the end of each shift and the need to report suspected diversion by an DON/Designee to the Board of Nursing. Background checks are to be completed on all new hires as well as agency. The DON/Designee will provide new staff with a detailed orientation regarding the handling of narcotics and the importance of maintaining a correct count of all narcotic medication. The DON will perform an audit of each medication cart each week to remove any discontinued narcotics. New hires are not allow to work/train until a background check is completed by Human Resources and	

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F 602	Continued From page 15 A review of Resident #247's May 2023 Physician's orders revealed an order for Oxycodone 10mg 1 tab by mouth 3 times daily that was discontinued on 5/18/23. A review of Resident #247's Controlled Medication Utilization Record initiated on 5/18/23 revealed 3 cards containing 30 pills of Oxycodone 10mg were received from the pharmacy. An annual MDS assessment dated 6/6/23 revealed Resident #247 was cognitively intact, required extensive assistance from 2 staff members to complete activities of daily living, and was coded as requiring pain medication. Resident #247 was discharged from the facility on 6/29/23. An interview was completed on 10/24/23 at 12:34pm with the Director of Nursing (DON). The DON stated on 7/7/23 she was contacted by Nurse #6 that 1 narcotic medication card containing 30 pills belonging to Resident #27 was unable to be accounted for on the D Hall medication cart. The DON stated when Nurse #7, 7:00am-3:00pm nurse, completed the narcotic medication count with Medication Aide (MA) #2, 3:00pm-11:00pm MA, the missing narcotic medication was discovered. Nurse #6 indicated the medication's Controlled Medication Utilization Record page was in the Narcotic Medication Count binder, but the card of medication was unable to be located. The DON stated Nurse #6 searched all medication carts and the medication storage room and was unable to locate the medications. She indicated Nurse #6 removed all discontinued narcotic medication cards and their Controlled Medication Utilization Records from	F 602	reviewed by the Executive Director. Current staff will be observed by the DON/Designee in person during the shift change narcotic count on varying shifts 3X per week for 4 weeks and then 1X per week for 2 months. The DON/Designee will reiterate the narcotics count protocol each month X 6 months and review the protocol with any new staff members in detail before allowing them to administer medications. DON/Designee will complete a monitoring tool to insure the narcotic count was accurate when compared to the count sheet. This monitor will occur 3 days/week for 4 weeks and then 1X/week for two months. The monitor will also include a visualization of the narcotics sheet to ensure two nurses signed off on the administration of narcotics given. The DON will present the plan will present to the QAPI team on 11/17/2023. Current Monitor results will be reviewed in QAPI once per month x 3 months and any updated recommendations will be made. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver. Alleged date of compliance 11/22/2023	

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the D Hall cart, placed them in a secure location for the DON to review when she arrived at the facility. The DON revealed Nurse #7 was suspended on 7/7/23 pending the outcome of the investigation, was not scheduled for any future shifts, and subsequently resigned on 7/12/23. The DON stated a drug screen was not completed on Nurse #7 prior to her leaving the facility on 7/7/23, and multiple attempts to contact her to follow up were unsuccessful. The DON stated on 7/10/23 she compared removed narcotic medications to the Utilization Records and discovered a total of 2 narcotic medication cards containing 30 pills each (belonging to Resident #27 and Resident #247) were missing. The DON revealed the facility had reported the missing narcotic medication to the police department and Drug Enforcement Agency.

An interview was completed on 10/24/23 at 1:06pm with MA #2. The MA stated when she counted the narcotic medications on D Hall cart at 3:00pm with Nurse #6, it was discovered 1 card of narcotic pain medication was missing. MA #2 stated she immediately notified Nurse #6 and the Nurse searched all carts and was unable to locate the missing narcotic medication card.

An interview was completed on 10/24/23 at 2:36pm with Nurse #7. The Nurse stated when she completed the narcotic medication count with MA #2 on 7/7/23, it was discovered 1 card of narcotic pain medication was missing. Nurse #7 stated she felt she mistakenly verified the narcotic medication count was correct when she counted with Nurse #8 at 7:00am on 7/7/23. The Nurse stated the facility suspended her pending the outcome of the investigation, but she did not return to work any future shifts at the facility.

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F 602	Continued From page 17 An interview was completed on 10/24/23 at 4:03pm with Nurse #6. The Nurse stated she was notified by MA #2 the narcotic medication count for D Hall cart was not correct. Nurse #6 stated she searched all medication carts for the missing narcotic pain medication card but was unable to locate it. The Nurse stated the narcotic pain medication card was a discontinued medication. Nurse #6 stated she, with another nurse as a witness, removed all discontinued narcotic medications and their corresponding Controlled Medication Utilization Record sheet from all medication carts and secured them for the DON to continue the investigation when she arrived. The Nurse stated Nurse #7 indicated she must have miscounted the narcotic medication cards with the 11pm-7am nurse. Nurse #6 stated on 7/10/23 the DON and herself matched all narcotic medication cards with their corresponding Controlled Medication Utilization Record sheets and discovered 2 narcotic pain medication cards were missing. An interview was completed on 10/25/23 at 11:25am with Nurse #8 (11pm-7am nurse). The Nurse verified she completed the narcotic medication count with Nurse #7 on 7/7/23 at 7:00am. Nurse #8 stated at that time the count was correct and Nurse #7 signed the Narcotic Count binder verifying the count was correct. An interview was completed on 10/26/23 at 1:45pm with the Medical Director. The Physician stated the Administrator notified him in July, unable to recall exact date, of a medication diversion and its plan to ensure another diversion would not occur. The Medical Director stated at this time he had no concerns of the facility's narcotic medication count and return to pharmacy	F 602		

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process.

An interview was completed on 10/26/23 at 2:04pm with the Administrator. The Administrator stated she believed the process of counting and ensuring the narcotic medication count was correct was not properly followed by the nursing staff.

Attempts to contact the facility's Pharmacy Consultant were unsuccessful.

The corrective action for the noncompliance dated 7/10/23 was as follows:

On 7/7/23 the DON was made aware of the allegation and began an initial investigation. Nurse #7 was suspended pending the outcome of the investigation. On 7/12/23 Nurse #7 resigned from her position at the facility. On 7/17/23 the investigation was concluded, and Nurse #7 was deemed responsible for the controlled drug diversion.

On 7/10/23 pain assessments were completed on current residents. No concerns were found during the assessments. An audit of all discontinued narcotic medication cards removed from medication carts were compared to their corresponding Utilization Record sheets revealing 2 narcotic pain medication cards were missing.

On 7/11/23 the facility sent in an Initial Report to the State Agency.

On 7/11/23 all current nursing staff signed a Zero Tolerance Regarding Drug Diversion.

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On 7/12/23 100% in-service training was initiated with all nurses and medication aides by the Administrator regarding proper narcotic medication counting, documenting on the Utilization Record sheets, verifying the number of narcotic cards and controlled Utilization Record match, and only the DON can remove discontinued controlled medications and their corresponding Controlled Medication Utilization record sheets from medication carts to be sent back to the pharmacy. In-services were to be completed by 7/14/23.
All newly hired nurses and Medication aides would be in-serviced by the DON/ADON during orientation.

Beginning 7/12/23 the DON or Assistant Director of Nursing (ADON) will complete a Correct Controlled Drug Count with Dispensing Sheet and Dispensing Card Audit on all medication carts 2 times weekly for 4 weeks and then weekly for 12 weeks. The audit will include verifying the controlled substance count is correct, the corresponding Controlled Medication Utilization Record Count matches the corresponding card of narcotic medication, and does the dispensing sheet have any discrepancies.

The DON will forward the results of the audits to the Quality Assurance (QA) Committee Meeting monthly until resolved.

A QA meeting was held 07/12/23 where the results of the investigation and audits were discussed.

On 7/13/23 the police, pharmacy, Medical Director, and DEA were notified of the drug diversion.

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F 602	Continued From page 20 On 7/17/23 the facility sent in an Investigation Report to the State Agency. The conclusion of the investigation revealed Nurse #7 was identified to have an incorrect count of controlled medications on the medication cart she was assigned to and was responsible for the diversion. The facility did not report Nurse #7 to the Board of Nursing. Past noncompliance was unable to be validated due to the corrective action plan not addressing the following components: how and when the facility would in-service agency nursing staff prior to their scheduled shift, what steps were to be used to screen new hires prior to working their first scheduled shift, how the facility would assure nursing staff were completing a correct controlled medication count with the oncoming nursing staff member at the beginning/end of each shift, and failure to report Nurse #7 to the Board of Nursing.	F 602		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		11/29/23

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F 610	Continued From page 21 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their policy related to misappropriation of property and exploitation in the areas of reporting to the state, investigating an allegation of misappropriation and exploitation, and protecting residents at risk as a result of not investigating. In addition, the Administrator failed to identify an allegation of misappropriation and exploitation when reported to her by the Business Office Manager. This was for 1 of 3 residents (Resident #397) reviewed for misappropriation of property. Findings included: The facility Policy and Procedures revised on 11/16/2022 stated, "Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Employee Misappropriation includes but is not limited to: Identity theft; Theft of money from bank accounts; Unauthorized or coerced purchases on a resident's credit card; Unauthorized coerced purchases from resident's funds; A resident who provides a gift to staff in order to receive ongoing care based on staff's persuasion; A resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in a financial crisis." The policy provided the following information on reporting, investigating, and protection of residents:	F 610	Resident 397's was discharged from the facility on 7/21/2023. The monies in question were deposited back into the Resident□s account, as evidenced by a bank statement, within (4) days after the unintentional misappropriation was resolved. A 24 hour and 5 day report will be submitted to the HCPR on 11/29/2023. The mock survey team performed a survey of Residents to insure no other Residents were affected. No other residents expressed concerns or recalled instances where they were affected by this alleged deficient practice. The Regional VP of Nursing has performed education with the Executive Director, Director of Nursing and Social Services Director regarding the State reporting criteria/time frames for reporting and the Consulate policy and procedure regarding Misappropriation of Resident Property on 11/16/2023. Education will be completed by 11/19/2023.To ensure accurate and timely reporting, all reported allegations of misappropriation will be reviewed by the Executive Director, DON and Social Services Director 5X per week for one month and then 1X per week for 2 months. The Mock Survey team will interview 10 random residents each week to determine any possibility of the need for a reportable investigation for 12 weeks.	

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5. The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation, and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Investigations will be accomplished in the following manner.
Investigation:
-The Abuse Coordinator and/or Director of Nursing shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse/ he/she shall also secure all evidence. Upon completion of the investigation, a detailed report shall be prepared.

6. Protection:
-Any suspect(s), who is an employee or contract service provider, once he/she has (have) been identified, will be suspended pending the investigation.
-The resident will be evaluated for any signs of injury, including a physical exam and/or psychosocial assessment, as appropriate.

7. Reporting/Response:
-Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or do not result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve

F 610

Any interviews found to trigger reporting, will immediately be presented to the Executive Director, DON and Social Services Director to insure any need for investigations/reporting are done timely.

Any Reportable incidents will be reviewed by the QAPI team monthly both for content and accurate reporting time frame. In addition, the Quality monitors performed by the Mock Survey Team will be reviewed each month. The QAPI team will make recommendations based on the monitors. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver.

Date of alleged compliance 11/29/2023.

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abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law.
-Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law."

Resident #397 was admitted to the facility on 10/7/2021.

Review of the Quarterly Minimum Data Set (MDS) dated 6/19/2023 revealed Resident #397 was cognitively intact.

A review of a group text message sent by the Business Office Manager (BOM) to sixteen other managers of the facility including the Administrator, Director of Nursing (DON), Unit Managers, and Social Service Director, on 6/21/2023 at 4:20 P.M. revealed Resident #397's debit card had been used for fraudulent charges. The BOM's text message revealed Resident #397 had given Nurse #4 permission to use the debit card but now there were multiple purchases made from a cash app (a smartphone application that can be used to transfer money from a linked bank account) for purchase at a grocery store, the purchase of a video game console, and Automated Teller Machine cash withdrawals.

An interview with the BOM on 10/24/2023 at 10:40 A.M. revealed on 6/21/2023 Resident #397

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wanted to know if she ran his debit card twice for Patient Monthly Liability fees, because Resident #397 received a postcard in the mail from his bank stating his bank account was overdrawn by $500.00. The BOM stated she assisted Resident #397 with calling the bank and that was when she heard Resident #397 mention to the bank that he had given Nurse #4 his debit card to help him turn his cell phone on. The BOM revealed Resident #397 was upset about Nurse #4 wiping out his bank account. The BOM revealed she reported the matter to all managers via a text message on 6/21/2023. She revealed she sent an email to the Administrator on 7/5/2023 because she did not know if the allegation was investigated by the management at the facility.

On 10/24/2023 at 10:57 A.M. the Administrator provided an email dated 7/5/2023 the BOM wrote to her where the BOM expressed her concerns about the money taken from Resident #397's bank account by Nurse #4 and how Resident #397 was upset.

Record review revealed no Facility Reported Incident had been reported to the state for the allegation of misappropriation related to Resident #397 that was referenced by the Business Office Manager in the 6/21/23 group text message sent to the 16 managers, including the Administrator.

The record review further revealed Resident #397 passed away on 8/3/2023.

During an interview with Unit Manager #2 on 10/25/2023 at 9:23 A.M. she revealed she was aware of the situation with Resident #397's debit card. She revealed she became aware of the allegation of missing funds after receiving a group

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text message from the BOM on 6/21/2023. She revealed the DON investigated the allegation. UM #2 revealed she did not participate in the investigation. She revealed she thought Nurse #4 was suspended while the facility investigated the matter.

During an interview on 10/26/23 at 2:28 P.M the DON revealed Resident #397 contacted her reporting Nurse #4 had not returned his debit card. The DON revealed she contacted Nurse #4 and asked him to return Resident #397's debit card. The DON revealed Nurse #4 came to the facility to return debit card and she cautioned him against taking any resident's debit card or money. She was unable to provide dates. The DON revealed she proceeded on vacation and did not know what happened of the matter. She stated the matter was being managed by the Administrator and she (the DON) was not aware if any investigation was conducted or if any report was made to the State Agency.

An interview on 10/25/2023 at 9:38 A.M. with the Social Service Director (SSD) revealed he did not participate in the investigation of the allegation. He stated he knew about the allegation after receiving a group text message on 6/21/2023 from the BOM.

In an interview with Nurse #4 on 10/24/2023 at 11:15 A.M. he revealed he gave Resident #397 his phone to transfer funds to his (Nurse #4's) cash app account to go pay for a phone for Resident #397. Nurse #4 stated he was not aware Resident #397 had saved his debit card on his cash app. Nurse #4 revealed after paying for Resident #397's phone charges, his cash app continued withdrawing funds from Resident

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#397's debit card amounts totaling to $1800.00. He indicated he was using his cash app to pay for his purchases and realized something was not right when there was no money coming out of his bank account. Nurse #4 stated he noticed his home rent payment was not taken out of his bank at the beginning of July 2023 and that was when he became concerned.

During an interview with the Administrator on 10/24/2023 at 10:57 A.M. she stated Nurse #4 had added Resident #397's debit card information to Nurse #4's cash app. She reported Nurse #4 was to make payment for a phone bill or a new phone for Resident #397. The Administrator revealed the BOM completed a verbal internal investigation and there was no documentation to the effect. The Administrator stated she spoke to Nurse #4 and realized it was a mix up. She rerorted Nurse #4's actions were not intentional. She stated she only did a verbal interview with Nurse #4 and did not have it documented. The Administrator confirmed she received the 7/5/2023 email from the BOM but denied receiving the text message on 6/21/2023. The Administrator stated Resident #397 and Nurse #4 had a good relationship and the misappropriation of the money by Nurse #4 was an unfortunate accident, unintentional and not deliberate misappropriation. She revealed Nurse #4 paid back amounts totaling $2256.36 to Resident #397 including bank fees.

A follow up interview with the BOM on 10/26/2023 at 12:02pm revealed she did not investigate the allegation. She stated she only alerted the administration (6/21/23 text message to administrative staff to include the Administrator) of what she found out from the resident and when

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F 610	Continued From page 27 she realized nothing was happening decided to send the Administration a detailed email (7/5/23) on the allegation. She stated she was not aware if the allegation was investigated or reported to the State Agency. During a follow up interview with the Administrator on 10/25/23 at 3:50 P.M. she revealed she did not find any need to make a report or investigate Nurse #4 using Resident #397's debit card. She stated the staff returned the money in 4 days and Nurse #4's cash app account got mixed up with Resident 397's bank account. She reported she did not find any need to do a facility reported incident. She stated she felt 5 days would not be enough to investigate the incident. She revealed an investigation was not necessary because Nurse #4's actions were accidental. She stated Resident #397 voluntarily gave Nurse #4 his debit card to go buy him a phone. She revealed Nurse #4 apologized to Resident #397 and that the Resident #397 was happy and satisfied. She stated Nurse #4 was a good nurse and she would not risk losing Nurse #4 just because of an unintended accident.	F 610		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 2 of 24 sampled residents whose MDS assessments were reviewed (Resident #43 and Resident #17).	F 641	On 10/24/23 resident #43 MDS assessment was updated to accurately reflect the residents' most recent fall by the Minimum Data Set Nurse. On 10/24/23 resident #17 MDS assessment	11/22/23

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The findings included:

1. Resident # 43 was admitted to the facility on 6/15/23.

Record review of the Change in Condition assessment dated 8/10/23 revealed Resident #43 had a fall at 12:00 pm and later complained of pain to right lower ankle and tibia (shin bone). An x-ray was ordered.

The radiology report dated 8/10/23 revealed Resident #43 had an avulsion fracture (a small chunk of bone attached to tendon/ligament gets pulled from the main part of the bone).

Review of Resident #43's Minimum Data Set (MDS) quarterly assessment dated 10/05/23 revealed she was not coded for the fall or fall with injury.

An interview was conducted on 10/24/23 at 12:50 pm with the MDS Nurse who revealed she was aware of Resident #43's fall and the quarterly assessment should have been coded for the fall. The MDS Nurse was not sure why she did not code the fall for Resident #43.

An interview was conducted with the Director of Nursing (DON) on 10/24/23 at 3:14 pm who revealed the MDS Nurse was responsible to code Resident #43's MDS assessment correctly.

An interview was conducted on 10/26/23 at 3:29 pm with the Administrator who revealed the MDS Nurse was responsible to ensure Resident #43's assessments were coded correctly.

F 641

was updated to accurately reflect the residents' indwelling catheter by the Minimum Data Set Nurse.
The Regional MDS Nurse performed quality improvement monitoring of the last 30 days of MDS assessments for accurately coding falls and indwelling catheters. Any issues identified were addressed.

The Minimum Data Set Nurse was re-educated by the Regional Minimum Data Assessment Nurse on accurate coding of the MDS. Newly hired MDS nurses will be educated upon hire. The Director of Nursing and/or Nursing Supervisor will perform Quality Improvement Monitoring of the MDS's for accurately coding of falls and indwelling catheters three times per week for 12 weeks.

The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement

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F 641	Continued From page 29 2. Resident #17 was admitted to the facility on 3/10/21. An Admission/Readmission Assessment dated 7/3/23 indicated Resident #17 had a urinary catheter in place. Resident #17's quarterly MDS assessment dated 7/11/23 revealed she was not coded as having an indwelling catheter. A Physician's order dated 7/3/23 stated provide Resident #17 urinary catheter care every shift and as needed. A review of the Resident's July 2023 Treatment Administration Record revealed nursing staff provided catheter care each shift. An interview was completed on 10/26/23 at 11:23am with the MDS Nurse. The MDS Nurse reviewed the quarterly MDS and confirmed it was inaccurate and indwelling catheter should have been checked. An interview was completed on 10/26/23 at 2:12pm with the Administrator. She revealed the MDS assessment should have accurately reflected the Resident's catheter use, and the inaccuracy was due to human error.	F 641	Committee monthly for three months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		11/22/23

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 31 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized person-centered care plan in the area of dementia for 1 of 3 residents reviewed for dementia care (Resident #40). The findings included: Resident #40 was admitted to the facility on 6/16/23 with a diagnosis of dementia without behavioral disturbance. The Minimum Data Set (MDS) significant change assessment dated 8/16/23 revealed Resident #40 was cognitively intact and was coded for a dementia diagnosis. Review of Resident #40's care plan last reviewed on 7/6/23 revealed there was not a care plan in place for Resident #40's dementia diagnosis. An interview was conducted with Unit Manager #1 on 10/26/23 at 8:41 am who revealed the MDS Nurse was responsible for resident care plans. During an interview on 10/26/23 at 8:55 am the MDS Nurse stated she was not responsible for developing the cognitive portion of resident care plans. The MDS Nurse stated the Social Worker was responsible to develop Resident #40's care plan for dementia. An interview on 10/26/23 at 9:00 am with the Social Worker revealed he was responsible for the cognitive portion of the resident care plans.	F 656	Resident #40 had their care plan updated with a dementia care plan on 10/26/23. The Social Services Director performed quality improvement monitoring of the current residents to ensure a dementia care plan was present if the resident has a diagnosis of dementia. The Minimum Data Set Nurse and Social Services Director was re-educated by the Regional Minimum Data Assessment Nurse on developing/implementing comprehensive care plan. Newly hired MDS nurses will be educated upon hire. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of the comprehensive care plans to ensure if the resident has a diagnosis of dementia, that a care plan was developed and implemented on 5 residents two times per week for 12 weeks. The Director of Nursing will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director,	

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F 656	Continued From page 32 The Social Worker stated he did not develop a care plan for Resident #40's dementia diagnosis because she was cognitively intact. An interview was conducted on 10/26/23 at 10:36 am with the Director of Nursing (DON) who revealed the MDS Nurse, and the Social Worker were responsible to develop the care plan for Resident #40's diagnosis of dementia.	F 656	Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and nurse practitioner interview the facility failed to transcribe and implement the nurse practitioner orders for two (Resident #30, Resident #21) of three residents reviewed for professional standards of practice. The Findings included: 1.Resident #30 was admitted to the facility on 5/19/21 with diagnoses that included hypoglycemia, chronic oppressive pulmonary disease, anxiety, end stage renal disease, atrial fibrillation, and congestive heart failure. Review of the Minimum Data Set dated 8/1/23	F 684	On 10/26/2023 an order clarification was completed for Resident #30. On 10/26/2023 an order clarification was completed for Resident #21. A quality review was completed by the Director of Nursing and/or designee on current residents□ orders with emphasis on transcription of doctor□s communications into Doctors' orders and ensure they are transcribed to the medication administration record/treatment administration record. Completed on 11/14/2023. No issues were identified.	11/22/23

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F 684	Continued From page 33 revealed she was assessed as having severely impaired cognition. Review of the facility Nurse Practitioner Acute Concern for the Doctor. note dated 10/20/23 revealed an order 1. Increase Amlodipine to 10 milligram po Daily. 2. Daily BP (blood pressure) x 5 days. (take at noon or later) (manual BP only). Review of Resident #30's Medication Administration record for October 2023 revealed blood pressure was checked on 10/20/23 and no further documentation of blood pressure checks until 10/26/23. There was no documentation on the October 2023 MAR to indicate the NP had ordered BP checks to be completed and no documentation BP checks were completed during the 5 days. On 10/26/23 at 12:41 PM an interview with the Nurse Practitioner was conducted. She stated that if she wrote an order for BP to be taken, she would expect it to be done. On 10/26/23 at 2:18 PM an interview with the Director of Nursing (DON) was conducted. The DON indicated the order was not transcribed correctly as it would have shown up on the MAR (medication administration record) to take the BP for 5 days. On 10/26/23 at 2:25 PM an interview was conducted with the Administrator. The Administrator stated that Resident #30's, NP order was missing the supplemental documentation page, and appeared as an incomplete order.	F 684	The Director of Nursing or designee re-educated current Licensed Nursing Staff on 11/09-11/15/2023 regarding transcription of doctor□s communications into Doctor□s orders and ensure they are transcribed to the medication administration record/treatment administration record.Education will be completed by 11/19/2023. All newly hired licensed nursing staff will receive this education during orientation. The Director of Nursing or designee will conduct random Quality Reviews of residents to ensure transcription of doctor□s communications into Doctor□s orders and ensure they are transcribed to the medication administration record/treatment administration record on 5 random residents 3 times a week for 4 weeks then weekly for 8 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Director of Nursing is responsible for implementing this plan. The results of the Quality Monitor will be presented to the QAPI committee monthly for updates and recommendations. Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing/designee will	

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(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

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2. Resident #21 was admitted to the facility on 7/13/15 with diagnoses which included hyperkalemia (high potassium), diabetes, and atrial fibrillation (irregular heartbeat).

Review of the Minimum Data Set (MDS) significant change assessment dated 8/03/23 revealed Resident #21 was cognitively intact.

Review of the BMP (Basic Metabolic Panel) laboratory results dated 10/19/23 revealed Resident #21's potassium was high at 5.4 mmol/L (millimoles per liter). Potassium at high levels in the blood could cause heart rhythm problems. The normal range for potassium was 3.5-5.1 mmol/L as referenced on the laboratory report sheet.

Review of the Acute Concerns for the Doctor report sheet dated 10/19/23 Nurse Practitioner #2 wrote the following orders for Resident #21 to be transcribed and carried out by nursing:

Give kayexalate (medication used to treat high potassium levels in blood) 15 grams by mouth x 1 dose.

BMP test on 10/23/23.

Review of Resident #21's physician orders from 10/19/23 through 10/25/23 revealed no order for the kayexalate and no order for the BMP laboratory test for 10/23/23.

An interview was conducted with Resident #21 on 10/25/23 at 4:30 pm who revealed she had not received the kayexalate medication and did not have blood work drawn on 10/23/23. She stated she had received kayexalate in the past but did

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report findings to the Quality Assurance Performance Improvement Committee monthly for three months.

Date of Alleged Compliance 11/22/2023

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F 684	Continued From page 35	F 684		

not have it recently.

An interview was conducted with the Unit Manager #1 on 10/25/23 at 4:39 pm who revealed she did not see NP #2's orders that were written on 10/19/23 until today. She stated she was not at the facility when the orders were received, and she did not have a copy placed in her box from the nurse who received the orders. Unit Manager #1 stated she reviewed new orders daily but did not know orders were given since they were not entered by Nurse #1.

An interview was conducted on 10/25/23 at 4:52 pm with Unit Manager #2 who revealed she shared responsibilities with Unit Manager #1 for Resident #21. The Unit Manager stated she did not get a copy of the Acute Concerns for the Doctor report sheet from Nurse #1, so she was not aware of the orders for Resident #21.

During an interview on 10/26/23 at 8:37 am with Nurse #1, who was assigned to Resident #21 on 10/19/23, revealed he did not recall the events of that day but stated when he received the Acute Concerns for the Doctor report sheet with orders, he normally entered the orders. Nurse #1 confirmed his initials were listed on the Acute Concerns for the Doctor report sheet, but he stated he must have missed the orders.

An interview was conducted on 10/26/23 at 12:03 pm with the Nurse Practitioner #2 who revealed she reviewed the Acute Concerns for the Doctor report sheet on 10/19/23 with Nurse #1 after she reviewed Resident #21's laboratory results. NP #2 stated the elevated potassium was a chronic issue for Resident #21 and the missed dose of kayexalate was not a great concern due to her

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F 684	Continued From page 36 history. She stated the lab test was reordered on 10/25/23 and the potassium level had self-corrected and was a normal range of 5.0 mmol/L. An interview was conducted on 10/26/23 at 1:47 pm with the Medical Director who revealed the missed dose of kayexalate for Resident #21 was not a concern. He stated he would not have treated a potassium level of 5.4 mmol/L for Resident #21 due to her hyperkalemia history.	F 684		
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. §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, record review, resident and staff interviews, the facility failed to place hand/wrist splint to the left hand for contracture management for 1 of 1 resident reviewed for	F 688	Resident had splint applied to left wrist on 10/25/2023. On 11/14/2023 a Quality review was	11/22/23

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F 688	Continued From page 37 limited range of motion (Resident #19). The findings included: Resident #19 was admitted to the facility on 8/13/13 with diagnoses which included hemiplegia, Parkinson's disease, and dementia. Review of Resident #19's active physician orders on 10/23/23 revealed an order dated 4/12/22 to wear left wrist splint while up in wheelchair as tolerated. Resident #19's care plan last reviewed on 4/11/23 revealed a care plan for the left wrist splint to wear at all times when up in wheelchair as tolerated and to check skin integrity of left wrist every shift. Review of the Minimum Data Set (MDS) quarterly assessment dated 7/14/23 revealed Resident #19 had severe cognitive impairment, he had clear speech, was able to clearly make his needs known, and he was able to understand others with clear comprehension. He was coded for limited range of motion (ROM) of the upper and lower extremities and was dependent on staff for dressing and personal hygiene. Resident #19 was not coded for behaviors including rejection of care. Review of the Kardex (care guide) Report (no date) revealed Resident #19 had an adaptive device and was to wear the left wrist splint at all times when up in wheelchair as tolerated. During an observation and interview on 10/23/23 at 9:53 am, Resident #19 was sitting in his wheelchair without the left wrist splint in place.	F 688	completed by the Director of Nursing and/or designee on current residents with and without splints to determine if the Residents with orders for splints were completed as written and ensure no orders were missing. Orders were reviewed and observations made to ensure splints were applied as ordered. Residents who have an order for a splint will be added to the TAR to ensure application of the splint is completed per physician orders. Existing and newly admitted Residents with new splint orders will be added to the TAR to ensure application as ordered. No issues were identified on the quality review. The Director of Nursing or designee re-educated current Licensed Nursing Staff on 11/09-11/15/2023 regarding splints to included current residents with orders for splints should have them applied as ordered. Education will be completed by 11/19/2023. All newly hired licensed nursing staff will receive this education during orientation. The Director of Nursing or designee will conduct random Quality Reviews of residents to ensure splints are being applied as ordered on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Director of Nursing is responsible for implementing this plan. The results of the Quality Monitor will be	

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F 688	Continued From page 38 His left wrist and left hand were observed to be flat to the wheelchair armrest with his 4 fingers slightly bent to the right. Resident #19's left wrist splint was observed on the bottom corner of the bed near the wall. Resident #19 stated he was not able to move his left arm all the way but could raise it a little and he could lay his left wrist flat on his wheelchair armrest. Resident #19 stated he did not know when he was supposed to wear the splint and he did not know how to put on the brace by himself. Resident #19 stated the staff did not put it on him and he was not able to remember when I was last on his wrist. Observations on 10/24/23 at 9:08 am, 12:09 pm, and 2:53 pm revealed Resident #19 was sitting in his wheelchair without the left wrist splint in place. The splint was observed on the bottom corner of the bed near the wall. An interview was conducted on 10/24/23 at 2:57 pm with Nurse Aide (NA) #3 who was assigned to Resident #19. NA #3 stated she did not place the left wrist splint on Resident #19 because she thought therapy staff was responsible for splints. She stated she did not have to document on the resident electronic care record for Resident #19's left wrist splint so she didn't put it on. NA #3 reported she did not know the last time Resident #19 had the splint on and she was not sure how long it was supposed to be on his left wrist. An interview was conducted with NA #4 on 10/24/23 at 2:59 pm who revealed she was not aware Resident #19 had a left wrist splint and she did not put in on him during her shift. NA #4 stated the splint did not show on the resident electronic care record for Resident #19.	F 688	present to the QAPI team each month for updates and or recommendations. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Date of compliance 11/22/2023	

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F 688	Continued From page 39	F 688		

During an interview on 10/24/23 at 3:03 pm Nurse #1 who was assigned to Resident #19 revealed the NA was responsible to place the left wrist splint on Resident #19. Nurse #1 stated he did not see the left wrist splint on Resident #19 for some time and he was not sure if the order was still active because he did not have to sign off on it.

An interview was conducted on 10/24/23 at 3:17 pm with the Director of Nursing (DON) who revealed she thought the therapy department was responsible for Resident #19's left wrist splint.

A telephone interview was conducted with the Rehabilitation Manager on 10/25/23 at 11:26 am who revealed therapy did not manage splinting for residents not on therapy services and Resident #19 was not on therapy services for his left wrist splint. The Rehabilitation Manager stated Resident #19's splint was managed by nursing and education was provided to staff regarding placement and monitoring of the left wrist splint.

An interview was conducted on 10/26/23 at 12:15 with Nurse Practitioner (NP) #3 who was assigned to Resident #19. NP #3 revealed she did not focus on splinting for Resident #19 but stated if a concern was identified she would refer back to therapy for services.

A telephone interview was conducted with the Medical Director on 10/26/23 at 1:47 pm who revealed the left wrist splint for Resident #19 was ordered not to correct the contracture but to avoid the contractures from worsening. The Medical Director stated he was not sure if there was a significant difference with Resident #19's left wrist/hand contractures from not having the splint

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F 688	Continued From page 40 in place.	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to discard expired medications stored for use in 1 of 1 medication storage room reviewed for medication storage. The findings included:	F 761	Tuberculin testing solution was discarded on 10/26/2023. No residents were affected by the alleged deficient practice. A quality review was completed by the Director of Nursing and/or designee on 10/27/2023 to ensure all Tuberculin test	11/22/23

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F 761	Continued From page 41 On 10/26/23 at 9:30am an observation was completed of the medication storage room with the Director of Nursing (DON). The observation revealed 1 multidose vial of opened and accessed Tuberculin Purified Diluted solution with an opened date of 9/14/23 located in the medication refrigerator. A review of the manufacturer's instruction label on the box indicated the medication should be discarded 30 days from the date medication was opened. An interview was completed on 10/26/23 at 9:35am with the DON. She indicated it was the Unit Manager's responsibility to check the medication room for expired medications. The DON stated the expired medication should have been discarded or returned to the pharmacy. An interview was completed on 10/26/23 at 10:01am with Unit Manager #1. The Unit Manager stated she checked the medication room monthly for expired medications. She revealed the room was checked in September 2023 for expired medications but was unable to recall the date. An interview was completed on 10/26/23 at 2:08pm with the Administrator. She stated expired medications should be discarded per the manufacturer's guidelines.	F 761	solutions have been dated upon opening and have not passed the manufacturer□s recommendations storage or expiration on 10/26/2023. A quality review was completed by the Director of Nursing and/or designee to ensure correct medication/biologicals storage. No issues were identified. The Director of Nursing or designee re-educated Nursing Staff on 11/09/2023 regarding medication storage to include dating upon opening and returning medications after manufacturer□s recommended storage time has expired. All newly hired nursing staff will receive this education during orientation. The Director of Nursing or designee will conduct random Quality Reviews of medication carts and medication room to ensure current medications are dated and stored per the manufacturer□s recommendations; 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Director of Nursing is responsible for implementing this plan. The results of the Quality Monitor will be presented to the QAPI committee monthly for updates and recommendations. Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary	

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F 761	Continued From page 42	F 761	Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing/designee will report findings to the Quality Assurance Performance Improvement Committee monthly for three months Date of alleged compliance 11/22/2023.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		11/22/23

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F 880	Continued From page 43 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 880	Resident #'s 86, 58, 6, 83, 37, and 147	

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interviews, the facility failed to offer hand hygiene to residents before meals when staff delivered lunch meal trays to resident rooms for 2 of 3 observations completed for dining (Resident #86, Resident #58, Resident #6, Resident #83, Resident #37, and Resident #147).

The findings included:

The facility policy titled "Infection Prevention and Control Program" last revised in October 2018 revealed the Infection Prevention and Control (IPCP) was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Review of the facility's Handwashing/Hand Hygiene Policy last revised August 2019 revealed the facility considered hand hygiene the primary means to prevent the spread of infections and that residents will be encouraged to practice hand hygiene. The policy further stated in part that alcohol-based hand rub or soap and water was to be used before eating food.

a. A continuous observation on Hall C on 10/23/23 at 1:08 pm through 1:12 pm revealed the following:

Medication Aide #1 was observed to enter Room 127 and deliver the lunch meal tray to Resident #86. Medication Aide #1 did not offer hand hygiene to the resident before eating.

The Infection Preventionist #2 was observed to enter Room 128 and deliver the lunch meal tray to Resident #58. The IP #2 did not offer hand

F 880

are being offered hand hygiene before meals. The mock survey team will be following up with these Residents to ensure compliance.

Other affected Residents will be offered hand hygiene before meals. The Mock Survey team will be following up during week day rounds to ensure handwashing before meals.

Staff was in-serviced by the DON/Designee on 11/09- 11/15/2023 regarding the infection control plan and the importance of offering handwashing/hand hygiene to Residents before meals. Education will be completed by 11/19/2023. Additional washcloths, pocket hand sanitizer and hand cleaning wipes will be provided to the staff. New staff will be trained on the infection Control policy to include the importance of Resident handwashing before meals. Resident handwashing/hygiene prior to meals will be monitored: 3X per day - 5 days per week for 4 weeks; then 2X per day 5 days per week for 4 weeks; and finally 1X per day 5 days per week for 4 weeks.

The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/17/2023. The Director of Nursing is responsible for implementing this plan. The results of the Quality Monitor will be presented to the QAPI team each month for updates and or recommendations. The

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F 880	Continued From page 45 hygiene to the resident before eating. Nurse Aide (NA) #1 was observed to enter Room 129 and deliver the lunch meal tray to Resident #6. NA #1 did not offer hand hygiene to the resident before eating. NA #2 was observed to enter Room 130 and deliver the lunch meal tray to Resident #83. NA #2 did not offer hand hygiene to the resident before eating. An interview was conducted on 10/23/23 at 1:12 pm with the Medication Aide #1 who was assigned to Hall C. She revealed she did not offer hand hygiene to Resident #86 when she delivered the lunch tray. She stated she did not pass meal trays often but was helping. Medication Aide #1 reported she did not know to offer hand hygiene to Resident #86. During an interview on 10/23/23 at 1:13 pm with the Infection Preventionist #2 she revealed she did not offer hand hygiene to Resident #58 when she delivered the lunch meal. She stated she did not normally pass meal trays and she assumed hand hygiene had already been completed today but she did not check with the NA to confirm it had been offered. During an interview on 10/23/23 at 1:14 pm with NA #1, who was assigned to Hall C, revealed she did not offer hand hygiene to Resident #6 when she delivered her lunch meal tray. NA #1 stated she had not received education to offer residents hand hygiene before meals and it was not something she had done before. During an interview on 10/23/23 at 1:21 pm NA	F 880	Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Date of alleged compliance 11/22/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING ______ B. WING ______	C 10/26/2023

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F 880	Continued From page 46 #2, who was assigned to Hall C, revealed she did not offer hand hygiene to Resident #33 when she delivered the lunch meal. She stated she was new to the facility and had not received education to offer hand hygiene to the residents before meals. During an interview on 10/24/23 at 3:18 pm the Director of Nursing revealed hand hygiene was to be offered to the residents prior to eating. The DON stated the staff had received hand hygiene education from the Infection Preventionist. An interview was conducted with the Infection Preventionist #1 on 10/26/23 at 10:12 am who revealed she provided general hand washing education but did not provide specific education to offer hand hygiene to the residents before eating. She stated the education focused on hand hygiene for staff when passing the meal trays, but she did not think to include hand hygiene for the residents. b. A continuous observation on Hall E on 10/23/23 at 1:02 P.M. through 1:08 P.M. revealed the following: Nurse Aide (NA) #9 was observed to enter Room #155 and deliver the lunch meal tray to Resident #37. NA #9 did not offer hand hygiene to the resident before eating. NA #9 was observed to enter Room #156 and deliver the lunch meal tray to Resident #147. NA #9 did not offer hand hygiene to the resident before eating.	F 880		

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F 880	Continued From page 47 In an interview with NA #9 on 10/23/23 at 1:10 P.M. NA #9 revealed she did not offer hand hygiene to Resident #37 when she delivered her lunch meal tray. She stated she was not aware it was necessary to offer hand hygiene unless a resident asked for it. NA #9 revealed she had not received education to offer hand hygiene to the residents before meals. During an interview with NA #9 on 10/23/23 at 1:10 P.M. NA #9 revealed she did not offer hand hygiene to Resident #147 when she delivered her lunch meal. She stated she was not aware it was necessary to offer hand hygiene unless a resident asked for it. NA #9 revealed she had not received education to offer hand hygiene to the residents before meals. During an interview on 10/24/23 at 3:18 P.M. the Director of Nursing (DON) revealed hand hygiene was to be offered to the residents prior to eating. The DON stated the staff had received hand hygiene education from the Infection Preventionist. An interview was conducted with the Infection Preventionist #1 on 10/26/23 at 10:12 A.M who revealed she provided general hand washing education but did not provide specific education to offer hand hygiene to the residents before eating. She stated the education focused on hand hygiene for staff when passing the meal trays, but she did not think to include hand hygiene for the residents.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		11/22/23

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F 883	Continued From page 48	F 883		

immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

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F 883	Continued From page 49 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer the pneumococcal vaccination to an eligible resident for 1 of 5 residents reviewed for immunizations (Resident #158). The findings included: The facility policy, Pneumococcal Vaccine last reviewed October 2019, read in part "residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty (30) days of admission unless medically contraindicated or previously vaccinated. The policy further stated for residents that receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record". Resident #158 was admitted to the facility on 7/10/23 with diagnoses which included dementia and diabetes.	F 883	A records search for Resident #158 showed he was given the Pneumococcal vaccine on 10/8/2019 at his previous facility. An audit of residents in the center was completed on 11/14/2023 by the DON/Designee to ensure that pneumococcal records are up to date. Residents eligible for the Pneumonia Vaccine will be noted on the quality monitor tool to ensure vaccine administered timely. Nursing staff were educated on 11/09-11/15/2023 regarding timely administration of vaccines.Education will be completed by 11/19/2023. New admission pneumococcal records will be requested upon admission, as well as medical records researched to determine eligibility by the Admissions Director, RN Unit manager and/or designee. The DON and or designee will monitor	

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F 883	Continued From page 50 Review of the Informed Consent for Pneumococcal Vaccine record dated 7/11/23 revealed the Resident Representative (RP) accepted and gave the facility permission to administer the pneumococcal vaccine to Resident #158. Review of the Minimum Data Set (MDS) admission assessment dated 7/17/23 revealed Resident #158's pneumococcal vaccine was not up to date. Review of Resident #158's immunization record on 10/24/23 revealed no documentation that the pneumococcal vaccine was administered. An interview as conducted with the Infection Preventionist (IP) #1 on 10/26/23 at 10:12 am. The IP revealed the Director of Nursing (DON) was responsible for all staff and resident immunizations. During an interview with the DON on 10/26/23 at 10:25 am, she revealed she was responsible for all staff and resident vaccinations. The DON stated vaccination consents were obtained for eligible residents and the vaccine would be administered. The DON was unable to state why Resident #158's accepted pneumococcal vaccine was not administered.	F 883	pneumococcal records every 30 days for 3 months and then quarterly for 2 quarters. The DON will present the plan to the QAPI committee on 10/17/2023. The QAPI Team will review the progress of accurate pneumococcal records every 30 days and adjust management accordingly. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver. Date of alleged compliance 11/22/2023.	