STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING ______ B. WING ______	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ROCKINGHAM	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite recertification survey was conducted 11/13/2023 through 11/16/2023. The facility was found out of compliance with the requirement CFR 483.73, Emergency Preparedness at E0037. Event ID# 8EH211	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		12/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/06/2023

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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E 037	Continued From page 1	E 037		

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

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E 037	Continued From page 2	E 037		

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

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E 037	Continued From page 3	E 037		

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness (EP) Plan. The findings included: A review of the facility's EP Plan last reviewed November 2023 revealed no documentation of the annual staff training. An interview was completed on 11/15/23 at 1:25 PM, the Regional Minimum Data Set (MDS) Consultant. She stated there was no documentation of staff annual training on the EP Plan. She stated the Staff Development Coordinator no longer worked at the facility and there had been management changes and it was	E 037	Corrective action for the resident affected. On 11/30/2023, the Administrator met with the Maintenance Director and reviewed the current emergency preparedness manual. The manual was updated with the new Administrators information, names and phone numbers of department heads and staff members. Corrective action for residents potentially affected. On 12/4/2023, the Maintenance Director placed the emergency preparedness manuals at each (2) nurse□s station, including placing one in the maintenance	

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E 037	Continued From page 5 overlooked. An interview on 11/15/23 at 2:50pm with Nursing Assistant (NA) #3. She stated that last time she received EP training was in 2021.	E 037	office and the Master copy in the Administrator□s office. Systemic Changes On 11/30/2023, the Administrator re-educated the Maintenance Director on the following: ¿ Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. ¿ Provide emergency preparedness training at least annually. ¿ Maintain documentation of all emergency preparedness training. ¿ Demonstrate staff knowledge of emergency procedures. On 12/5/2023, the Maintenance Director initiated an in-service to staff on the emergency preparedness plan, including policies and procedures, where the emergency binder is located for any emergent needs and after-hours usage. Staff that did not receive this training by 12/12/2023, will be taken off the schedule until the training has been completed. This training will become a part of the new hire orientation process. The Maintenance Director will randomly audit 2 employees personal files weekly times 4 weeks, then 4 employees personal files monthly times 3 months, to ensure that they have received the required emergency preparedness training utilizing the QA Monitoring Tool for	

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E 037	Continued From page 6	E 037	emergency preparedness training. Quality Assurance The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Maintenance Director for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 11/13/2023 through 11/16/2023. Event ID#8EH211 10 of the 10 complaint allegations did not result in deficiency. The following intakes were investigated NC000202749, NC00207419, and NC00205802.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		12/14/23

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F 636	Continued From page 7 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive	F 636		

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F 636	Continued From page 8 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the required time frame for 4 of 19 residents selected to be reviewed for Resident Assessments (Residents #20, #178, #180 and #182). The findings included: A. Resident #20 was admitted to the facility on 3/17/23. A record review was completed 11/15/2023. Resident #20's most recent annual MDS was dated 10/5/23. The electronic medical record indicated this assessment was "in process" and had not been completed. B. Resident #178 was admitted to the facility on 10/3/23. A record review was completd 11/15/2023. Resident #178's most recent MDS was dated 10/9/23 and was coded as an admission	F 636	Corrective Action for the Resident Affected Resident #20s MDS Assessment Reference date 10/5/23 completed on 11/15/2023. Resident #178s MDS Assessment Reference date 10/9/23 completed on 11/15/2023. Resident #180s MDS Assessment Reference date 10/7/23 completed on 11/15/2023. Resident #182s MDS Assessment Reference date 10/17/23 completed on 11/15/2023. Action for the Residents Potentially Affected One 12/01/2023, the Case Mix Director reviewed the assessment status report to identify any outstanding Comprehensive MDS assessments. Of 13 assessments reviewed, 0 assessments needed to be	

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F 636	Continued From page 9 assessment. The electronic medical record indicated this assessment was "in process" and had not been completed. C. Resident #180 was admitted to the facility on 10/3/23. A record review was completed 11/15/2023. Resident #180's most recent MDS was dated 10/7/23 and was coded as an admission assessment. The electronic medical record indicated this assessment was "in process" and had not been completed. D. Resident #182 was admitted to the facility on 10/13/23. A record review was completed 11/15/2023. Resident #182's most recent MDS was dated 10/17/23 and was coded as an admission assessment. The electronic medical record indicated this assessment was "in process" and had not been completed. On 11/15/23 at 9:56 AM, an interview occurred with MDS Nurse #1 who stated the MDS assessments for Residents #20, #178, #180 and #182 had not been completed as required. She explained that there had been an ongoing issue with the former Social Worker not completing her areas of the MDS assessment in the required time frame. She had gone to the former Administrator and created calendars for the Social Worker so she would know when to complete her sections of the MDS assessments. In addition, MDS Nurse #1 stated they were in the process of getting the assessments completed and transmitted.	F 636	completed. Systemic Changes On 11/29/2023, the Clinical Reimbursement Consultant in-serviced the Administrator and the MDS nurses on Timeliness of Comprehensive assessments. On 12/05/2023, the Administrator in-serviced the DHS, Dietary Manager, Therapy Coordinator, Social Worker, and Activity Director on completing on Timeliness of Comprehensive assessments. Any newly hired staff will receive this training in the orientation process. The MDS Coordinator and Administrator will run the assessment due report to identify resident assessments that are outstanding for completion weekly times 4 weeks and then monthly times 4 months, utilizing the QI Monitoring Tool for Comprehensive Assessment and Timing. Any assessments that have not been completed in a timely manner. Quality Assurance The MDS Coordinator will present the analysis of the Comprehensive Assessment and Timing to the Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance.	

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F 636	Continued From page 10	F 636	Date of compliance: December 14, 2023	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required time frame for 5 of 19 residents selected to be reviewed for Resident Assessments (Residents #10, #63, #64, #18 and #19). The findings included: A. Resident #10 was admitted to the facility on 6/27/23. A record review was completed 11/15/2023. Resident #10's most recent MDS was dated 9/29/23 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in process" and had not been completed. B. Resident #63 was admitted to the facility on 4/1/23. A record review was completed 11/15/2023. Resident #63's most recent MDS was dated 9/27/23 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in process" and	F 638	Corrective Action for the Resident Affected Resident #10s MDS Assessment Reference date 9/29/23 completed on 11/15/2023. Resident #63s MDS Assessment Reference date 9/27/23 completed on 11/15/2023. Resident #64s MDS Assessment Reference date 8/30/23 completed on 11/15/2023. Resident #19s MDS Assessment Reference date 8/21/23 completed on 11/15/2023. Resident #18s MDS Assessment Reference date 10/01/23 completed on 11/15/2023. Action for the Residents Potentially Affected On 12/1/2023, the MDS Coordinator ran an assessment status report to identify outstanding Quarterly MDS. Of 13 assessments reviewed, 0 assessments needed to be completed.	12/14/23

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Continued From page 11
had not been completed.

C. Resident #64 was admitted to the facility on 3/16/23.

A record review was completed 11/15/2023. Resident #64's most recent MDS was dated 8/30/23 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in process" and had not been completed.

On 11/15/23 at 9:56 AM, an interview occurred with MDS Nurse #1 who stated the quarterly MDS assessments for Residents #10, #63, and #64 had not been completed as required. She explained that there had been an ongoing issue with the former Social Worker not completing her areas of the MDS assessment in the required time frame. She had gone to the former Administrator and created calendars for the Social Worker so she would know when to complete her sections of the MDS assessments. In addition, MDS Nurse #1 stated they were in the process of getting the assessments completed and transmitted.

4. Resident #19 was admitted on 4/1/23.

Review of Resident #19's electronic medical record revealed a quarterly Minimum Data Set (MDS) Assessment dated 8/21/23 that read "in process" and had not yet been completed.

Resident #19's next quarterly MDS Assessment dated 10/25/23 that read "in process" and had not yet been completed.

On 11/15/23 at 9:56 AM, an interview was

F 638

Systemic Changes

On 11/29/2023, the Clinical Reimbursement Consultant in-serviced the Administrator and MDS nurses on Timeliness of Quarterly assessments.
On 12/5/2023, the Administrator in-serviced the DHS, Dietary Manager, the Therapy Coordinator, Social Worker and Activity Director on completing on Timeliness of Quarterly assessments. Any newly hired staff will receive this training in the orientation process.
The MDS Coordinator and Administrator will run the assessment due report to identify resident assessments that are outstanding for completion weekly times 4 weeks and then monthly times 4 months, utilizing the QI Monitoring Tool for Quarterly Assessments at Least Every 3 Months. Any assessments that have not been completed in a timely manner.

Quality Assurance

The MDS Coordinator will present the analysis of the Quarterly Assessments that are due every 3 months to the Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance.

Date of compliance: December 14, 2023

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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
F 638	Continued From page 12 completed with MDS Nurse #1 who stated the quarterly MDS assessments for Resident #19 had not been completed as required. She explained that there had been an ongoing issue with the former Social Worker (SW) not completing her area of the MDS assessment within the required time frame. She stated she informed the former Administrator about the late MDS assessments. The MDS Nurse #1 stated she created and updated calendars for the SW so she would know when she needed to complete her area of the MDS assessments. In addition, MDS Nurse #1 stated they were in the process of getting the assessments completed and transmitted. 5. . Resident #18 was admitted to the facility on 7/31/2019. A review of Resident #18's most recent quarterly MDS was dated 10/1/2023. The electronic medical record indicated the assessment was "in process" and had not been completed. On 11/15/23 at 9:56 AM, an interview occurred with MDS Nurse #1 who stated the quarterly MDS assessment for Resident #18 had not been completed in the time frame required. She stated there had been an ongoing issue with the former Social Worker not completing her areas of the MDS assessment in the required time frame. MDS Nurse #1 stated she made the Administrator aware. MDS Nurse #1 stated the facility was currenly working to transmitt all past due assessments.	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement-	F 640		12/14/23

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	345378	A. BUILDING ______ B. WING ______	C 11/16/2023

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F 640	Continued From page 13	F 640		

§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that

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F 640	Continued From page 14 does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment within the required timeframe for 1 of 3 residents reviewed for discharge. (Resident #33). The findings included: Resident #33 was admitted to the facility on 9/20/2023. A record review was completed 11/15/2023. Resident #33's medical record revealed the resident was discharged to the hospital on 10/17/2023. The discharge Minimum Data Set (MDS) assessment was not transmitted. During an interview with the MDS nurse on 11/15/2023 at 9:56AM. She indicated she failed to complete the discharge MDS and transmit it. She further stated the Administrator was made aware of the past due assessments. Most were waiting for the Social Worker to complete her part. The Social Worker was no longer employed with the facility and the facility was currently working to transmit all past due MDS assessments. During an interview with the Director of Nursing (DON) on 11/15/23 at 10:00AM, She stated Resident #33 was sent to the hospital directly	F 640	Corrective Action for the Resident Affected On 11/15/2023, resident #33s Minimum Data Set, (MDS) assessment with Assessment Reference Date (ARD) of 10/17/23 was completed and submitted to Internet Quality Assessment Instrument, (IQIES) with accepted date of 11/16/2023. Action for the Residents Potentially Affected On 12/2/2023, the MDS Coordinator ran an assessment status report to identify outstanding MDS for transmission to the IQIES. Of 13 MDSs that needed to be transmitted, 13 were transmitted by 12/6/23. Systemic Changes On 11/29/2023, the Clinical Reimbursement Coordinator initiated an in-service to the MDS Coordinators on Encoding/transmitting Resident Assessments per, Resident Assessment Instrument, (RAI) guidelines. Any new MDS nurse hired will receive this training during the orientation process.	

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F 640	Continued From page 15 from the dialysis center on 10/17/2023. The discharge MDS assessment should have been completed and transmitted within the required timeframe.	F 640	The Administrator will run the assessment due report to identify resident assessments to ensure the assessment have been transmitted on time utilizing the QI (Quality Improvement) Monitoring Tool for encoding/transmitting resident assessments weekly times 4 weeks and then monthly times 4 months. Quality Assurance The MDS Coordinator will present the analysis of the findings the Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. Date of compliance: December 14, 2023	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of weight loss. This was for 1 (Resident #14) of 19 residents assessments reviewed. The findings included: Resident #14 was admitted on 6/22/23.	F 641	Corrective Action for the Resident Affected On 11/15/2023, resident #14s MDS modified to correct coding to indicate a weight loss in Section K0300 during the Assessment Reference Date (ARD) lookback.	12/14/23

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F 641	Continued From page 16 Review of Resident #14's electronic medical record read a weight of 128 pounds on 7/26/23 and 8/15/23. His weight on 9/18/23 was 114 pounds. Review of Resident #14's quarterly MDS dated 9/21/23 read his weight was 114 pounds and not coded for any weight loss. An interview was completed on 11/16/23 at 9:30 AM with the Dietary Manager (DM). She stated she coded Resident #14 with no weight loss and it was a mistake. She stated Resident #14 should have been coded to a weight loss. An interview was completed on 11/16/23 at 9:45 AM with the Director of Nursing (DON). She stated Resident #14's quarterly MDS should have been coded for weight loss.	F 641	Action for the Residents Potentially Affected On 12/5/2023, the MDS Coordinator completed a 100% review of all current residents with a significant weight loss. Of the 12 residents with a significant weight loss 11 were coded correctly on the current MDS, section K, with 1 Resident modification for section K on 12/5/23 for accuracy. Systemic Changes On 11/29/2023, the two MDS nurses received education related to the accuracy of assessments per the RAI guidelines by the Clinical Reimbursement Coordinator On 12/5/2023 the Administrator in-service the DHS, Dietary Manager, the Therapy Coordinator, Social Worker and Activity Director on accuracy of assessment completion. Any newly hired staff will receive this training during the orientation process. The Director of Healthcare Services, Administrator, and or Dietary Manager will review the accuracy of 3 assessments per week times 4 weeks, then 5 assessments per month for 3 months utilizing the QA Monitoring Tool for Accuracy of Assessments for weight loss, section K. Any inaccuracies noted will be corrected at the time of the review. Quality Assurance The results of the MDS accuracy reviews	

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F 641	Continued From page 17	F 641	will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: December 14, 2023	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		12/14/23

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F 657	Continued From page 18 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff and previous Social Worker (SW), the facility failed to revise a care plan in the area of advanced directives for 1 of 19 residents (Resident #77) reviewed. The findings included: Resident #77 was admitted to the facility 6/5/2023 with diagnoses that included end stage renal disease and pneumocystis pneumonia. The resident's significant change in status Minimum Data Set (MDS) dated 8/17/2023 indicated the resident had severely impaired decision-making ability. The resident's care plan was last updated 8/23/2023 and contained a focus for advanced directives. The care plan indicated the resident wished to remain a full code. The resident's medical record contained a paper copy of a Do Not Resuscitate (DNR) order dated 8/17/2023. A review of Resident #77's medical record revealed a physician's order for hospice consult/referral. The order was dated 8/17/2023. On 11/15/2023 an interview was conducted with MDS Nurse #1. She stated the lack of communication by the SW and the lack of documentation by the SW lead to the care plan	F 657	Corrective Action for the Resident Affected Resident #77 was discharged on 8/26/2023. Action for the Residents Potentially Affected On 12/1/2023, the MDS Coordinator reviewed residents□ charts for Do Not Resuscitate (DNR) order. Of 77, resident in-house, 21 had DNR orders and 56 did not have DNR orders. The MDS Coordinator reviewed the residents care plans to ensure that if they had a DNR that it was reflected in the care plan. Of the 77 care plans reviewed, the 21 residents with a DNR status, the DNR status was addressed appropriately. Systemic Changes On 11/29/2023, the Clinical Reimbursement Consultant in-serviced the MDS nurses and the Administrator on the timing and revisions of comprehensive care plan utilizing the Resident Assessment Instrument RAI and company policy. On 12/5/2023, the Administrator in-service the DHS, ADHS, the Therapy Coordinator, Social Worker, and Activity Director on timing and revision of a comprehensive	

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F 657	Continued From page 19 not getting revised on 8/23/2023 to reflect the new DNR order.	F 657	care plan utilizing the Resident Assessment Instrument (RAI) and company policy. The Clinical Reimbursement Consultant and or the Administrator will review three resident□s comprehensive care plans for weekly times four weeks and then two resident□s comprehensive care plans monthly times three months to ensure timing revision of the comprehensive care plan for Code Status, utilizing the QA Monitoring Tool for comprehensive care plans. Quality Assurance The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Clinical Reimbursement Consultant and or Administrator for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: December 14, 2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		12/14/23

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F 658 Continued From page 20

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to accurately transcribe the physician order for a protective skin covering (Resident #71) for 1 of 1 resident reviewed for skin impairments.

The findings included:

Resident #71 was originally admitted to the facility on 7/19/23 with diagnoses that included weakness and protein-calorie malnutrition.

A skin assessment dated 7/20/23 indicated Resident #71 had an intact pink/red area to her coccyx.

Review of the physician orders included an order dated 8/2/23 for a foam dressing to the coccyx area every seven days. The order revealed it to be scheduled on Monday, Wednesday, and Thursday at 9:00 PM.

The most recent Minimum Data Set (MDS) assessment dated 9/11/23 indicated Resident #71 had moderately impaired cognition. She was free from any pressure ulcers or other skin impairments.

Resident #71's active care plan, last reviewed 9/12/23, included a problem area for being at risk for development of pressure injuries related to decreased mobility and incontinence.

The Director of Nursing (DON) was interviewed on 11/15/23 at 3:30 PM and stated Resident #71 used the foam dressing to her coccyx as protection due to her bony prominence. The DON

F 658

Corrective Action the Resident Affected

On 11/15/2023, a clarification order was written for resident #71 for a protective skin covering by the Director of Healthcare Services, (DHS).

Action for the Residents Potentially Affected

On 11/29/2023, the DHS and/or Administrative Nurses reviewed residents with orders for protective skin coverings to ensure that the correct orders were written. Of the 5 residents with protective skin covering orders written, all 5 had orders for protective skin coverings.

Systemic Changes

On 11/29/2023, the DHS in-serviced the Licensed Nurses on ensuring if a resident has an order for a protective skin covering, that there is an order, and it specifies the protective covering needed. Any Licensed Nurses that do not receive the in-service training by 12/12/2023, will be taken off the schedule until the training is completed. Any newly hired Licensed Nurses will receive this training during the orientation process.

The DHS and or Administrative Nurses will randomly monitor 1 resident weekly times 4 weeks, then 2 residents monthly times 3 months to ensure they have order protective skin coverings utilizing the QA Monitoring Tool for services provided

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F 658	Continued From page 21 was the nurse that put the order in on 8/2/23. She explained that the Nurse Practitioner initiated the protective foam dressing for every seven days in Resident #71's electronic medical record. The DON then activated the order to ensure it went on the Medication Administration Record. She further stated she inadvertently put the frequency to change the dressing every Monday, Wednesday, and Thursday instead of once a week as ordered. She felt this was an oversight.	F 658	meet professional standards, (protective skin coverings). Quality Assurance The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Nurse Practitioner and staff interviews, the facility failed to provide care and maintenance, such as flushing the PICC line and changing the dressing to Resident #179's Peripherally Inserted Central Catheter (PICC) line. This occurred for 1 of 1 resident (Resident #179) reviewed for surgical wounds.	F 694	Corrective Action the Resident Affected On 11/14/2023, an order was obtained to remove the peripherally inserted central catheter, (PICC) for resident #179. On 11/14/2023, care and maintenance were provided to the PICC line and the dressing was changed per MD orders by the charge nurse.	12/14/23

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The findings included:

Resident #179 was admitted to the facility on 11/3/23 with multiple diagnoses that included sepsis, perforation of the intestine and colostomy status.

A review of Resident #179's hospital discharge summary dated 11/3/23 indicated that she received intravenous (IV) antibiotics but did not mention a PICC line and did not have any orders for the care or maintenance of the resident's PICC line.

The 5-day Minimum Data Set (MDS) assessment dated 11/5/23 revealed Resident #179 was cognitively intact and was coded with an IV access. She was not coded with any antibiotic use.

Review of the active physician orders dated 11/3/23 to 11/13/23 revealed no physician orders for the care and maintenance of Resident #179's PICC line.

On 11/14/23 at 1:05 PM, a surgical wound care observation was completed to Resident #179's abdominal wound with Nurse #1. The surgical wound was clean and dry with wound care completed as ordered. Resident #179 had her left arm lifted to her head and a PICC line was observed to the left upper arm. The date on the dressing was 11/3/23 and the site was without redness or drainage.

Nurse #1 was interviewed on 11/14/23 at 1:56 PM and stated she was aware Resident #179 had a PICC line but couldn't answer why the resident did not have orders for the care and maintenance

F 694

Action for the Residents Potentially Affected

On 11/29/2023, the DHS and/or Administrative Nurses reviewed residents with parenteral IV fluids to ensure that orders were written for providing care and maintenance. Of the one resident on parenteral IV fluids, 0 required orders to be corrected.

Systemic Changes

On 11/30/2023, the DHS in-serviced the Licensed Nurses on ensuring if a resident has a parenteral IV, that an order needs to be written for the care and maintenance of the device. Nurses that do not receive the in-service training by 12/5/2023, will be taken off the schedule until the training is completed. Any newly hired Licensed Nurses will receive this training during the orientation process.
The DHS and or Administrative Nurses will randomly monitor 1 resident weekly times 4 weeks, then 2 residents monthly times 3 months to ensure that if a resident has a parenteral/PICC line, that they have orders written and orders for the care and maintenance of the device utilizing the QA Monitoring Tool for parenteral IV fluids.

Quality Assurance

The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS for review by the

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F 694	Continued From page 23 of the PICC line. She added that to flush the PICC line and change the dressing, there had to be a physician's order. On 11/16/23 at 8:28 AM, a phone interview was completed with Nurse #3 who was familiar with Resident #179. She was aware there was a PICC line present but was unable to state why there were no orders for the care and maintenance of the PICC line. Nurse #2 was interviewed on 11/16/23 at 855 AM. She was the admitting nurse for Resident #179 on 11/3/23 and stated she was aware a PICC line was present to her left upper arm. Stated a phone call should have occurred to the physician/Nurse Practitioner to either obtain an order to discontinue or for the care and maintenance of the PICC line. She felt it was an oversight that she did not do this. On 11/16/23 at 9:38 AM, a phone interview occurred with the Nurse Practitioner (NP). She stated she was aware of a PICC line being in place which was free from any concerns during her assessments of Resident #179 but thought there were orders already in place for the care and maintenance of the PICC line. During an interview with the Director of Nursing (DON) on 11/15/23 at 3:30 PM, she stated when a resident was admitted with an IV device the admitting nurse should call the physician/NP and either obtain orders to maintain/care for the IV device or have it discontinued. She felt it was an oversight.	F 694	Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		12/14/23

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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Continued From page 25

by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews with staff and Social Worker (SW), the facility failed to have complete and accurate medical records in the area of social services for 2 of 3 residents (Resident #77, Resident # 51) reviewed for closed records.

The findings included:

Resident #77 was admitted to the facility 6/5/2023 with diagnoses that included end stage renal

F 842

Corrective Action the Resident Affected

For resident #77, he expired in the facility on 08/26/2023.
For resident #55, appropriate arrangements were made, however, documentation was not provided. Social Worker no longer works at the facility.

Action for the Residents Potentially Affected

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F 842	Continued From page 26 disease and pneumocystis pneumonia. The resident's significant change in status Minimum Data Set (MDS) dated 8/17/2023 indicated the resident had severely impaired decision-making ability. A review of Resident #77's medical record revealed a physician's order for hospice consult/referral. The order was dated 8/17/2023. Resident #77's medical record was reviewed on 11/14/2023 did not contain SW notes regarding a referral to hospice or hospice admission prior to the resident's death in the facility on 8/26/2023. On 11/15/2023 at 9:54 AM a phone interview with the previous SW. She stated her last day of employment with the facility was a week ago. The SW stated she sent the referral to Pruitt Health Hospice via email and most of the communication between her and Pruitt Hospice and the Financial Manager was conducted via email. The SW stated she thought she had documented in the resident's medical record. 2. Resident #51 was admitted to the facility on 9/21/2023 with diagnoses that included osteomyelitis of the left foot. Resident #51's medical record contained a discharge assessment by Nurse Practitioner #1 with referral to home health for skilled nursing and aide, physical therapy and/or occupational therapy to evaluate and treat as indicated as well as skilled nursing for wound management. A review of Resident #51's medical record completed on 11/14/2023 did not contain SW	F 842	On 12/5/2023, the Administrator reviewed residents that were discharged home over the past 30 days. Of the 7, discharges, 7 were found to have proper documentation in their records by the Business Office Manager. There were 0 discharges found without proper documentation. Systemic Changes The facility hired a new Director of Social Services with a start date of 11/28/2023. During the orientation process, the Social Worker and or Business Office Manager will receive education on proper documentation and follow through for residents that are discharged home, including setting up home health, hospice referrals and durable medical equipment. This in-service will be part of the new orientation process for new hired Social Services or Business Office Manager. The Administrator will randomly monitor residents that are scheduled for discharge. If any residents have been discharged, the record will be reviewed times 4 weeks, then monthly times 3 months to ensure they have proper documentation in their charts and that appropriate home health agencies were set up, utilizing the QA Monitoring Tool for resident records identifiable information. Quality Assurance The results of these reviews will be submitted to the Quality Assurance	

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F 842	Continued From page 27 notes regarding the resident's disposition, home health referral, or skilled nursing referral for wound management. On 11/14/2023 at 3:38 PM a phone interview was conducted with Resident #51. He stated he initiated the discharge home. The SW told him she sent his referral to home health, and they would contact him to set up a visit. The resident stated after he arrived home, the SW called and informed him the home health company she referred him could not provide service. She told him she would send the referral out to other agencies. The SW made him an appointment with the wound clinic, and he followed up with the wound clinic until he could get home health set up. On 11/14/2023 at 3:47 PM a second phone interview was conducted with the SW. She stated Resident #51 only gave the facility a few hours notice that he was going home with his wife. She discussed an Against Medical Advice (AMA) discharge with the Administrator. The Administrator told her to avoid an AMA discharge, if possible. The SW stated she made the referral to the home health agency that serviced the resident prior to his admission to the facility. The agency declined the referral, and she sent the referral out to several other agencies. Resident #51 discharge home with a vacuum assisted wound device (wound vac). She called the wound clinic and made Resident #51 a follow up appointment until they could get home health in place. The SW stated she did not document any action taken regarding the resident's discharge because she was more concerned with getting the services he needed in place.	F 842	Performance Improvement (QAPI) Committee by the Administrator for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	

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F 849	Continued From page 28	F 849		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849		12/14/23

§483.70(o) Hospice services.
§483.70(o)(1) A long-term care (LTC) facility may do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the

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F 849	Continued From page 29 communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration	F 849		

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F 849	Continued From page 30	F 849		

of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives

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F 849	Continued From page 31 and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest	F 849		

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F 849 Continued From page 32
practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews with staff and previous Social Worker (SW), the facility failed to complete a referral to hospice for 1 of 3 residents (Resident #77) reviewed for closed records.

The findings included:

Resident #77 was admitted to the facility 6/5/2023 with diagnoses that included end stage renal disease and pneumocystis pneumonia.

The resident's significant change in status Minimum Data Set (MDS) dated 8/17/2023 indicated the resident had severely impaired decision-making ability.

The resident's care plan was last updated 8/23/2023 and contained a focus for advanced directives. The care plan indicated the resident wished to remain a full code.

The resident's medical record contained a Do Not Resuscitate (DNR) order dated 8/17/2023.

A review of Resident #77's medical record revealed a physician's order for hospice consult/referral. The order was dated 8/17/2023.

Resident #77's medical record reviewed on 11/14/2023 did not contain SW notes regarding a referral to hospice, hospice admission, hospice care plan, or hospice nursing progress notes prior to the resident's death in the facility on 8/26/2023.

On 11/15/2023 at 9:54 AM a phone interview with

F 849

Corrective Action the Resident Affected

Resident #77, expired on 08/26/2023.

Action for the Residents Potentially Affected

On 11/30/2023, the DHS and/or Administrative Nurses reviewed residents with orders for Hospice Referrals. Of the one referral made, one order was written, and Hospice services evaluated the residents for Hospice Services within 7 days.

Systemic Changes

On 12/5/2023, the DHS in-serviced the Licensed Nurses on ensuring if a resident has an order/consult for Hospice, that the referral is made the same day the order/consult is received. Any Licensed Nurses that do not receive the in-service training on or before 12/14/2023, will be taken off the schedule until the training is completed. Any newly hired Licensed Nurses will receive this training during the orientation process.

The DHS and or Administrative Nurses will review the activity report from Matrix, (electronic health records) 5 times a week times 4 weeks, then 2 times a week for 4 weeks, then monthly, to ensure if a hospice referral/consult is made, that the

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F 849	Continued From page 33 the previous SW. She stated her last day of employment with the facility was a week ago. The SW stated she sent the referral to Pruitt Health Hospice via email. She further stated with some insurances, the resident will become a private pay when they transition to hospice, so Resident #77 was not transitioned to hospice services with Pruitt Health. She stated she spoke with the business office regarding the referral. She did not send the referral to agencies outside of Pruitt Health. The SW stated she did not know why there were no SW notes regarding the reason for not transitioning the resident to hospice. She explained most of the communication between her and Pruitt Hospice and the Financial Manager was conducted via email. She did not have access to those emails any longer. On 11/15/2023 at 10:25 AM an interview was conducted with the Financial Manager. She stated insurance was not the reason Resident #77 did not get referred to hospice. He was managed Medicaid and that did not prevent the resident from receiving reimbursement for hospice services with Pruitt Health Hospice. She did not recall any communication, email or otherwise, regarding Resident #77's referral to hospice. 11/15/23 10:28 AM Interview with the Regional MDS Consultant. She stated she contacted Pruitt Health Hospice, and they never received a referral for Resident #77. She was not sure why the referral was never made. The SW was responsible for making sure the hospice referral was completed. An interview was conducted with the Director of Nursing (DON) on 11/16/2023. She stated it was	F 849	hospice agency is notified, and services are provided. This review will be monitored utilizing the QA Monitoring Tool for Hospice Services. Quality Assurance The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	

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F 849	Continued From page 34 her expectation that residents with hospice referrals/consults be provided hospice services if they qualify.	F 849		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		12/14/23

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F 867	Continued From page 35 systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.	F 867		

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	345378	A. BUILDING ______ B. WING ______	C 11/16/2023

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F 867	Continued From page 36 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867

Continued From page 37

Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification surveys conducted on 3/26/2021 and 8/31/2022 and during a complaint investigation conducted 5/24/2023. This was for 2 deficiencies that were cited in the area of accurate assessments and care plan revision. The deficient practice areas were recited on the current recertification and complaint survey on 11/16/2023. The duplicate citation of F641 during four federal surveys and F657 during two consecutive federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAPI program.

The findings included:

This citation is cross referenced to:

F 641: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the area of weight loss. This was for 1 (Resident #14) of 19 residents assessments reviewed.

During a complaint investigation conducted 5/24/2023 the facility failed to code the Minimum Data Set assessment accurately in the area of Activities of Daily Living.

During the facility's recertification survey 8/31/2022 the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of medication, nutrition, cognition, mood, and pain.

F 867

Corrective Action the Resident Affected

On 11/30/2023, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT)to discuss the 2 repeat tags, F641 and F657. It was determined through the Root Cause Analysis that the facility had a deficient practice of previous social worker in job performance, care planning and assessments.

Corrective action for residents potentially affected

On 12/4/2023 the Administrator and Regional Nurse Consultant educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys.

On 12/5/2023, the Administrator reviewed surveys for 03/26/2021, 08/31/2022 and 05/24/2023, to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI meetings.

Systemic Changes

The Area Vice President of Operations for Coastal North Division, and or the Regional Nurse Consultant and or the Clinical Reimbursement Consultant will attend the monthly QAPI meetings to

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F 867	Continued From page 38 During the facility's recertification survey 3/26/2021 the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medication, Preadmission Screening and Resident Review Level II, cognition, indwelling urinary catheter, skin conditions, tobacco use, bowel and bladder, and activities of daily living. F 657: Based on record review, interviews with staff and previous Social Worker (SW), the facility failed to revise a care plan in the area of advanced directives for 1 of 19 residents (Resident #77) reviewed. During the facility's recertification survey 8/31/2023 the facility failed to review and revise the care plan in the areas of fall interventions, pressure ulcers, and urinary incontinence. In the absence of the Interim Administrator, an interview was conducted with the Regional MDS Coordinator on 11/16/2023 at 9:50AM. She stated the QAA committee is comprised of all department heads, the Medical Director, Nurse Practitioner, and Pharmacy Consultant. The Regional MDS Consultant stated lack of oversight was the reason for repeat citations.	F 867	ensure that the repeat tags are monitored, monthly times 6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI process. Quality Assurance The results of these ongoing survey trend reviews are to be submitted in the QAPI meeting and placed in the QAPI minutes for review. The Quality monitoring schedule will be modified based on the findings of the monitoring review. The QAPI Committee will evaluate and modify the monitoring schedule as needed. Compliance Date: 12/14/2023	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must	F 947		12/14/23

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F 947	Continued From page 39 be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure annual dementia training was completed for 2 Nursing Assistants (NA #1 and NA #2) of 5 reviewed for staffing. The findings included: NA #1's date of hire (DOH) was 2/6/18. Review of NA #1's Education/In-service records did not include evidence of dementia training. NA #2's DOH was 11/2/21. Review of NA #1's Education/In-service records did not include evidence of dementia training. In an interview on 11/15/23 at 1:10 PM, the Regional Minimum Data Set (MDS) Consultant. She stated the facility did not have a Staff Development Coordinator so when it was discovered that NA #1 and NA #2 did not have annual dementia training, they completed the training today. The Consultant stated there had been a lot of turnover in management staff and due to the lack of oversight.	F 947	Corrective Action the Resident Affected For NA #1, with a hire date of 2/6/18, she completed her dementia training on 11/15/2023. For NA#2, with a hire date of 11/2/21, she completed her dementia training on 11/15/2023. Action for the Residents Potentially Affected On, 12/5/2023 the Administrator and Director of Healthcare Services reviewed the nurse aide trainings on Dementia. 33 of 46 Nurse Aides working had received their dementia training within the 12 months of hire, and 13 Nurse Aides required their training. Systemic Changes On 11/29/2023, the Regional Nurse	

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F 947	Continued From page 40	F 947	Consultant, assigned the Communication and people with Dementia course through the PruittHealth Care learning portal to the staff. Employees that have not taken this course by 12/12/2023 will be taken off the schedule until it is completed. This course will be a part of the new orientation process for all new hires. Quality Assurance The Administrator and or Director of Healthcare Services and or the Director of Healthcare will randomly monitor 2 employees learning portal 2 times a week, times 4 weeks, then 2 monthly times 3 months to ensure they have taken the course on communication and people with Dementia utilizing the QA Monitoring Tool for required in-service training for Nurse Aides. The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or DHS and reviewed by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 12/14/2023	