STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345393	A. BUILDING _____ B. WING _____	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PISGAH MANOR HEALTH CARE CENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/3/23 through 12/6/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GB4H11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/3/23 through 12/6/23. Event ID# GB4H11. The following intakes were investigated: NC00197902, NC00198270, NC00199232, NC00201108, NC00205180, NC00205976, NC00206000, NC00206016, NC00206018, NC00206257, and NC00207896. 14 of the 22 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		1/2/24

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

Electronically Signed | 12/29/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to maintain a resident's dignity by not providing assistance to a resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 7 residents reviewed for dignity. The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity and not having to wait for incontinence care after having a bowel movement. Findings included:	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 550	Continued From page 2 Resident #66 was admitted to the facility on 10/9/23 for mononeuritis complex (damage to different areas of the peripheral or sometimes the brain nervous system that can cause paralysis, tingling, numbness, pain, and changes in brain function), osteoarthritis and depression. Resident #66's admission Minimum Data Set (MDS) dated 10/22/23 indicated she was cognitively intact. She required extensive assistance with bed mobility, and total dependence with transfer and toileting. Resident #66 was always incontinent of bladder and was frequently incontinent of bowel. The resident had clear speech and had clear comprehension during assessment. During an attempt to interview on 12/3/23 at 11:58 PM, Resident #66 looked at the surveyor but would not answer questions. She had laid still in bed with hands crossed over her abdomen and stared at the ceiling most of the time. Resident's room had a mild smell of a bowel movement during interview. During an interview on 12/3/23 at 11:59 AM, Resident #66's family member stated that on 12/2/23, she noticed the resident had a bowel movement and wet her brief when she checked the resident at around 9:30 AM. Family member stated she turned the call light on as soon as she noticed it. She waited for almost an hour, and nobody came to check on what they needed even though the call light was on. The family member stated she was aggravated and went out to the hallway looking for a staff member. She stated she could not find the nurse aide, so she asked for assistance from the medication nurse that was in the other hallway. The nurse assisted the	F 550	F550 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/3/23 resident #66, was provided incontinent care and receives incontinent care daily. Staff were made aware of the requirement to provide incontinent care for resident # 66 and to answer the call light timely and were in serviced on these requirements beginning 12/22/2023. This education completed by 12/29/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 12/22/2023 the Director of Nurses (DON) and Assistant Dir of Nursing (ADON) conducted an audit of all residents to determine if call lights were being answered and incontinence care was being provided timely in a manner to ensure that residents rights to a dignified existence are being maintained. Education was initiated on 12/22/2023 for all staff by the Director of Nurses and Staff Development Nurse (SDC)Consultant on ADL Care, Call Bells, Care Needs Requirements and Resident Rights and completed 12/29/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/22/2023, the DON and SDC began	

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F 550	Continued From page 3	F 550		

family member in cleaning Resident #66 and in changing the resident's brief at around 10:30 AM. The family member stated it happened a lot when she visited, and it happened again the next day on 12/3/23. She stated she came in after 9:30 AM and checked on Resident #66. She stated the resident had a bowel movement and wet her brief again. The family member stated she did not press the call light because she asked the lady who was passing out ice if she could send the nurse aide in to help her clean and change the resident's brief. The family member stated nobody came to check on them except for the nurse aide who came at around 12:10 PM that day to assist in cleaning the resident.

During an interview on 12/5/23 at 10:00 AM, the hospice nurse stated Resident had declined a lot within seven weeks due to her condition. She stated resident went from walking and feeding herself to being bed bound and total assist with feeding. She stated the resident was able to communicate some days depending upon which nerve was flaring up. The hospice nurse stated the resident's family had complained a lot about the call light not being answered immediately.

During an interview on 12/5/23 at 11:50 AM with Nurse #1, she stated that she was the nurse assigned to Resident #66 on first shift from 7:00 AM to 3:00 PM on 12/2/23. She stated she was almost done passing out medications that morning when Resident #66's family member asked her to help with cleaning the resident up and changing her brief. She stated there was one nurse aide assigned to W hall, but the family member stated she could not find her. Nurse #1 stated she stopped passing out medications and assisted the resident's family member in

education of all full time, part time, as needed, agency nurses and CNA□s, department managers, housekeeping, activities and therapy staff on facility policy on assuring that residents are treated with respect and call devices answered timely, along with applicable resident rights related to dignity. Education will be completed by 12/28/2023 at which time all of the above must be in-serviced prior to working.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nurses or Designee will monitor compliance beginning 12/26/2023 utilizing the F550 Resident Rights Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents are receiving incontinence care, they have access to a call device and that their dignity is being maintained as it pertains to the timely response to the need for staff assistance. The DON/designee will monitor that residents are being treated in a dignified manner by auditing resident satisfaction with call bell response time weekly x 2 and monthly x 3. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will

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F 550	Continued From page 4 providing incontinence care. She stated she did not notice if the call light was on when she went into the resident's room. Nurse #1 stated Resident #66 had a bowel movement and was wet. She stated there was no redness or irritation. The resident was not wet through her brief and stool was not dried on her. During an interview on 12/6/23 at 10:20 AM, Nurse Aide (NA) #1 stated she worked on W hall on 12/2/23 and 12/3/23. She stated that she was assigned to two other halls and had around 18 to 20 residents those days. NA #1 stated she was doing her first round and was trying to get residents to sit up on their chairs by herself. She stated she was busy in S hall and was not aware that Resident #66's call light was on. She stated Resident #66's family member talked to her after lunch and told her they were not happy with having to wait for a long time and it was the same when the family member visited in the past. The nurse aide stated another staff told her before lunch on 12/3/23 that Resident #66's family member needed help with changing the resident's brief. She stated she was busy trying to finish giving a shower to a resident and trying to finish rounds on S hall and was not able to get to them immediately. She went to assist the family member at around 12:10 PM. NA #1 stated Resident #66 had a medium bowel movement and had wet her diaper, but she did not notice any red areas on her bottom. During an interview on 12/6/23 at 3:30 PM, the Feeding Assistant stated she was passing out ice on 12/3/23 when Resident #66's family member asked her to have the nurse aide help her change the resident's brief at around 10:00 AM to 10:30 AM. She stated she told the nurse aide when she	F 550	be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, Staff Development, MDS Coordinator, Therapy Manager, Activities Director, Social Worker, and Environmental Services Director. Date of Compliance: 1/2/2024	

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F 550	Continued From page 5	F 550		

saw her in the other hallway, but the nurse aide was also busy assisting a resident. The Feeding Assistant stated she was not sure when the nurse aide went to assist the family member, but she told the nurse aide mid-morning between breakfast and lunch on Sunday (12/3/23).

During an interview on 12/6/23 at 9:05 AM, another family member stated he came in everyday to care for Resident #66. He stated he came in at 11:30 AM on 12/2/23 to feed the resident and the visiting family member told him she was upset about Resident #66 not being cleaned up for a long time until she had to get the nurse to help her.

During a follow up telephone interview on 12/5/23 at 2:43PM, Resident #66's family member stated she turned the call light on as soon as she got in on 12/2/23 at around 9:30 AM and noticed the resident had wet her brief and had a bowel movement. After an hour, she got up and walked up and down the hallway looking for a staff to assist her but did not see anybody. She stated she found the nurse in the other hallway and asked her to help. The family member stated she turned the call light off when she went back to the resident's room with the nurse. She stated Resident #66 was considered cognitively impaired because of her condition and would not be able to communicate if she was wet or had a bowel movement. She stated on 12/3/23, she did not turn the call light on and just sent a message through the staff passing out ice that she needed assistance with cleaning up Resident #66. The family member stated it was very frustrating because the resident laid there the whole time with a bowel movement and a wet brief until the nurse aide came in at 12:10 PM.

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F 550	Continued From page 6 During an interview on 12/6/25 at 5:00 PM, the Director of Nursing stated the staffing numbers on the weekends were not different on any other day. There were no ancillary staff during the weekends to help with answering the call lights. The nurse and the nurse aide were responsible for answering the call lights on the weekends and assist residents with their needs such as changing their brief. She also stated her goal was to increase staffing.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of cognitive patterns, mood, behavior, and participation in assessment and goal setting for 2 of 6 residents (Resident #57 and Resident #11) whose MDS were reviewed. The findings included: 1. Resident #57 was admitted on 8/17/23. The admission Minimum Data Set (MDS) assessment dated 8/30/23 for Resident #57 indicated the questions in the sections for cognitive patterns, mood, behavior, and participation in assessment and goal setting were not assessed.	F 641	The Statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F641 Accuracy of Assessments For resident #57 a corrective action was obtained on 12/6/2023 by modifying and correcting MDS assessment for assessment reference date of 8/20/2023. Coding of question was corrected to accurately reflect that resident did have	1/2/24

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F 641	Continued From page 7 An interview with the Social Services Director on 12/6/23 at 8:52 AM revealed she just started in her new role in October 2023, but she was responsible for filling out the sections for cognitive patterns, mood, behavior, and participation in assessment and goal setting in the MDS assessments. An interview with the MDS Coordinator on 12/6/23 at 3:56 PM revealed the previous SSD left and ended her notice sooner than required. The MDS Coordinator stated that the previous SSD was already gone when she realized that her sections in the MDS had not been filled out. She stated she went ahead and transmitted Resident #57's MDS even though some sections had not been assessed but all questions should have been answered and signed by the person who completed the assessment. An interview with the Administrator on 12/6/23 at 6:16 PM revealed because Resident #57's MDS was due, the MDS Coordinator went forward with closing them even though they weren't completed. A follow-up interview with the Administrator on 12/6/23 at 7:48 PM revealed she had completed an assessment on 8/30/23 for the sections that the SSD should have completed on Resident #57's MDS but it had already been closed at that time. She documented the assessment on a separate Social Services form by hand and it included questions about resident review, behavior, advanced directives, discharge planning, psychiatric consult, PASRR (Preadmission Screening and Resident Review), and social and transportation. She stated she communicated this to the MDS nurses, but she	F 641	resident interviews for cognition, mood and behaviors during the specified lookback timeframe. Correction was completed by the MDS Coordinator on 12/22/2023. For resident #11 a corrective action was obtained on 12/6/2023 by modifying and correcting MDS assessment for assessment reference date of 8/21/2023. Coding of question was corrected to accurately reflect that resident did have resident interviews for cognition, mood and behaviors during the specified lookback timeframe. Correction was completed by the MDS Coordinator on 12/22/23. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of all current residents who have had an MDS completed during the past 60 days was completed in order to identify all residents for coding accuracy in Section C, D and E of the Minimum Data Set (MDS). This audit was conducted by the MDS Coordinator, on 12/18/2023. Audit Results: 17 residents reviewed were noted with accurate coding of section C, D, E _____0_ residents reviewed were identified as having inaccurate coding of section C, D, E All residents identified with inaccurate coding in section C, D, E had a modification of the affected assessment and the coding was corrected.	

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F 641	Continued From page 8 was not sure if a modification would have been done and she did not know if this required a modification. 2. Resident #11 was admitted on 9/14/20. The annual Minimum Data Set (MDS) assessment dated 8/31/23 for Resident #11 indicated the questions in the sections for cognitive patterns, mood, behavior, and participation in assessment and goal setting were not assessed. An interview with the Social Services Director on 12/6/23 at 8:52 AM revealed she just started in her new role in October 2023, but she was responsible for filling out the sections for cognitive patterns, mood, behavior, and participation in assessment and goal setting in the MDS assessments. An interview with the MDS Coordinator on 12/6/23 at 3:56 PM revealed the previous SSD left and ended her notice sooner than required. The MDS Coordinator stated that the previous SSD was already gone when she realized that her sections in Resident #11's MDS had not been filled out. She stated she went ahead and transmitted the MDS even though some sections had not been assessed but all questions should have been answered and signed by the person who completed the assessment. An interview with the Administrator on 12/6/23 at 6:16 PM revealed because Resident #11's MDS was due, the MDS Coordinator went forward with closing them even though they weren't completed.	F 641	Modification and correction completed by the MDS Coordinator on 12/22/2023. Corrected MDS were re-submitted on 12/27/2023 in MDS Batch # 1385. Systemic Changes On 12/21/2023 an in-service training for the facility Social Worker was provided by the MDS Coordinator that included the importance of accurate coding of the assessment process for sections C, D and E. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Social Worker or Minimum Data Set Nurse initiated auditing 12/26/2023 using the Accurate Coding of MDS Audit Tool of residents for coding accuracy in Sections C,D,E of the MDS for cognition, mood, and behaviors during the specific lookback time frame. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance Committee by the MDS Nurse to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Asst Dir of Nursing, MDS Coordinator, Therapy Manager, Staff Development Coordinator, Social Worker, Environmental Services Dir and Activities Dir.	

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F 641	Continued From page 9 A follow-up interview with the Administrator on 12/6/23 at 7:48 PM revealed she had completed an assessment on 8/31/23 for the sections that the SSD should have completed on Resident #11's but the MDS had already been closed at that time. She documented the assessment on a separate Social Services form by hand and it included questions about resident review, behavior, advanced directives, discharge planning, psychiatric consult, PASRR (Preadmission Screening and Resident Review), and social and transportation. She stated she communicated this to the MDS nurses, but she was not sure if a modification would have been done and she did not know if this required a modification.	F 641	Date of Compliance: 1/2/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		1/2/24

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F 644	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR), level II was completed after new mental health diagnoses for 2 of 3 residents (Resident #37, #39) reviewed for PASRR. The findings include: 1. Review of Resident #37's medical record revealed the resident was admitted to the facility on 11/16/18 and a PASRR level I was completed. The resident was diagnosed with anxiety disorder on 10/07/22 and other phobic anxiety disorder on 10/13/22. No PASRR level II was completed. During an interview on 12/06/23 at 8:53 AM with the Social Worker (SW) revealed she had begun her position as SW in October 2023 and had no knowledge why a PASRR level II had not been completed for Resident #37 when she received new mental health diagnosis. She stated a PASRR level II should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. The SW revealed the admissions coordinator would inform her if a resident required a PASRR level II upon admission and she also attends weekly behavior meetings and daily morning meetings where the team would discuss any residents with a change of condition or a newly added diagnosis that could also require a PASRR level II to be completed. She stated based on Resident #37 recent diagnosis of anxiety disorder and other phobic anxiety disorder a PASRR level II should have been completed.	F 644	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F644 Coordination of PASRR and Assessments For residents # 37 & # 39, a corrective action was obtained on 12/06/2023. " The specific deficiency was corrected on 12/11/2023 by facility Social Services Director submitting a new request for resident review for resident #37 & #39 through NCMUST. " For residents #37 & #39 a new request for resident review were submitted to NCMUST on 12/6/2023 by the facility Social Services Director. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/6/2023, the Social Worker completed 100 % audit of all residents who have had a new diagnosis assigned to them from 12/6/2023 in order to validate that the State Mental Health	

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	345393	A. BUILDING _____ B. WING _____	C 12/06/2023

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F 644	Continued From page 11 During an interview on 12/06/23 at 6:16 PM with the Administrator she revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #37 recent diagnosis of anxiety disorder and other phobic anxiety disorder a PASRR level II should have been completed. 2. Review of Resident #39's medical record revealed the resident was admitted to the facility on 08/20/19 and a PASRR level I was completed. The resident was diagnosed with major depressive disorder on 06/12/23. No PASRR level II was completed. During an interview on 12/06/23 at 8:53 AM with the Social Worker (SW) revealed she had begun her position as SW in October 2023 and had no knowledge why a PASRR level II had not been completed for Resident #37 when she received new mental health diagnosis. She stated a PASRR level II should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. The SW revealed the admissions coordinator would inform her if a resident required a PASRR level II upon admission and she also attends weekly behavior meetings and daily morning meetings where the team would discuss any residents with a change of condition or a newly added diagnosis that could also require a PASRR level II to be completed. She stated based on Resident #39 recent diagnosis of major depressive disorder a PASRR level II should have	F 644	Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation Audit results are: 20 residents were identified as having been assigned a new diagnosis of Severe Mental Illness and/or Intellectual Disability. 10 of 20 residents already have been screened and assigned Level II PASRR. __15__ of 20 have PASRR screenings that are up to date. __5__ of 20 do not have up to date PASRR screening. These 5 were submitted to NC Must on 12/26/2023. Systemic Changes On 12/21/2023, the MDS Coordinator completed an in service training for the facility Social Services Director and that included the importance of thoroughly reviewing each resident□s medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. The education also included the importance of ensuring that the state mental health authority is notified via NCMUST of all residents who have received these diagnoses and/or if these residents have a significant change in status. This information has been integrated into	

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F 644	Continued From page 12 been completed. During an interview on 12/06/23 at 6:16 PM with the Administrator she revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #39 recent diagnosis of major depressive disorder a PASRR level II should have been completed.	F 644	the standard orientation training for new Social Services Directors and Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Social Worker or Minimum Data Set Nurse initiated auditing 12/26/2023 residents who have a diagnoses of a severe mental illness or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they have a significant change in status or are newly diagnosed with above diagnoses, using the quality assurance survey tool entitled PASRR Screening Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Asst Dir of Nursing, Minimum Data Set Coordinator, Therapy Manager, Staff Development Coordinator, Social Worker, Environment Services Director and the Activity Director	

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F 644	Continued From page 13	F 644	Date of Compliance: 1/2/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, family and staff interviews, the facility failed to provide incontinence care to a dependent resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 6 residents reviewed for activities of daily living. Findings included: Resident #66 was admitted to the facility on 10/9/23 for mononeuritis complex (damage to different areas of the peripheral or sometimes the brain nervous system that can cause paralysis, tingling, numbness, pain, and changes in brain function), osteoarthritis and depression. Resident #66's care plan on 10/10/23 indicated a problem with bladder incontinence with increased risk for skin breakdown and infections. Interventions included notifying nursing if incontinent during activities, establishing voiding patterns when possible and providing assistance with all incontinence care. Resident #66's admission Minimum Data Set (MDS) dated 10/22/23 indicated she was cognitively intact. She required extensive assistance with bed mobility, and total	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #66 was provided ADL incontinence care on 12/3/23 and the DON/designee has made daily observations to ensure that this resident has received timely ADL and incontinent care. 2. Corrective action for residents with the potential to be affected by the alleged	1/2/24

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F 677	Continued From page 14 dependence with transfer and toileting. Resident #66 was always incontinent of bladder and was frequently incontinent of bowel. She had not exhibited rejection of care behaviors. Resident #66 was impaired on both upper and lower extremities. During an attempt to interview on 12/3/23 at 11:58 PM, Resident #66 looked at the surveyor but would not answer questions. She had laid still in bed with hands crossed over her abdomen and stared at the ceiling most of the time. Resident's room had a mild smell of a bowel movement during interview. During an interview on 12/3/23 at 11:59 AM, Resident #66's family member stated that on 12/2/23, she noticed the resident had a bowel movement and wet her brief when she checked the resident at around 9:30 AM. Family member stated she turned the call light on as soon as she noticed it. She waited for almost an hour, and nobody came to check on what they needed even though the call light was on. The family member stated she was aggravated and went out to the hallway looking for a staff member. She stated she could not find the nurse aide, so she asked for assistance from the medication nurse that was in the other hallway. The nurse assisted the family member in cleaning Resident #66 and in changing the resident's brief at around 10:30 AM. The family member stated it happened a lot when she visited, and it happened again the next day on 12/3/23. She stated she came in after 9:30 AM and checked on Resident #66. She stated the resident had a bowel movement and wet her brief again. The family member stated she did not press the call light because she asked the lady who was passing out ice if she could send the	F 677	deficient practice. All residents in the facility have the potential to be affected. On 12/22/2023, the Director of Nurses and Assistant Dir of Nurses conducted an audit of all residents to determine if ADL/ incontinence care were being provided and no negative findings were identified. On 12/22/2023, the Director of Nurses, and staff Development Coordinator initiated the following education to all licensed nurses and certified nursing assistants, full time, part time, agency, and PRN staff to be completed by 12/29/2023: " Rounds and Timely Incontinent Care " Call Bell Response " Timely ADL Care " What to do when there is a change in the schedule 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 12/22/2023, the Director of Nurses and the STAFF Development Nurse initiated education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What to Do When There is a Change in the Schedule. The education on Rounds and Timely Incontinence Care, Call Bell Response, ADL Care, and What	

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F 677	Continued From page 15 nurse aide in to help her clean and change the resident's brief. The family member stated nobody came to check on them except for the nurse aide who came at around 12:10 PM that day to assist in cleaning the resident. During an interview on 12/5/23 at 10:00 AM, the hospice nurse stated Resident had declined a lot within seven weeks due to her condition. She stated resident went from walking and feeding herself to being bed bound and total assist with feeding. She stated the resident was able to communicate some days depending upon which nerve was flaring up. The hospice nurse stated the resident's family had complained a lot about the call light not being answered immediately. During an interview on 12/5/23 at 11:50 AM with Nurse #1, she stated that she was the nurse assigned to Resident #66 on first shift from 7:00 AM to 3:00 PM on 12/2/23. She stated she was almost done passing out medications that morning when Resident #66's family member asked her to help with cleaning the resident up and changing her brief. She stated there was one nurse aide assigned to W hall, but the family member stated she could not find her. Nurse #1 stated she stopped passing out medications and assisted the resident's family member in providing incontinence care. She stated she did not notice if the call light was on when she went into the resident's room. Nurse # 1 stated Resident #66 had a bowel movement and was wet. Nurse # 1 stated Resident #66 had a bowel movement and was wet. She stated there was no redness or irritation. The resident was not wet through her brief and stool was not dried on her. During an interview on 12/6/23 at 10:20 AM,	F 677	to Do When There is a Change in the Schedule will be completed by all licensed nurses and nursing assistants, full-time, part-time, agency staff, and PRN staff by 12/29/2023. Any employee who has not received this education will not be allowed to work until the training has been completed. This includes licensed nurses and nursing assistants full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will complete weekly audits to ensure that ADL/incontinence care are provided in a timely manner. These audits began on 12/26/2023 by the Director of Nursing or designee. The audits described above will be completed using the QA Monitoring Tool for ADL□s. These audits will include a sample of 5 residents 3 x weekly x 2 weeks, then weekly x 2 weeks then monthly x 2 months. Results will be reported to the weekly Quality Assurance Committee by the Director of Nurses or designee to ensure corrective action is initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, Staff Development Coordinator, MDS Coordinator, Therapy Director, Activities Dir, Social Worker, and	

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F 677	Continued From page 16 Nurse Aide (NA) #1 stated she worked on W hall on 12/2/23 and 12/3/23. She stated that she was assigned to two other halls and had around 18 to 20 residents those days. NA #1 stated she was doing her first round and was trying to get residents to sit up on their chairs by herself. She stated she was busy in S hall and was not aware that Resident #66's call light was on. She stated Resident #66's family member talked to her after lunch and told her they were not happy with having to wait for a long time and it was the same when the family member visited in the past. The nurse aide stated another staff told her before lunch on 12/3/23 that Resident #66's family member needed help with changing the resident's brief. She stated she was busy trying to finish giving a shower to a resident and trying to finish rounds on S hall and was not able to get to them immediately. She went to assist the family member at around 12:10 PM. NA #1 stated Resident #66 had a medium bowel movement and had wet her diaper, but she did not notice any red areas on her bottom. During an interview on 12/6/23 at 3:30 PM, the Feeding Assistant stated she was passing out ice on 12/3/23 when Resident #66's family member asked her to have the nurse aide help her change the resident's brief at around 10:00 AM to 10:30 AM. She stated she told the nurse aide when she saw her in the other hallway, but the nurse aide was also busy assisting a resident. The Feeding Assistant stated she was not sure when the nurse aide went to assist the family member, but she told the nurse aide mid-morning between breakfast and lunch on Sunday (12/3/23). During a follow up telephone interview on 11/5/23 at 2:43 PM, Resident #66's family member stated	F 677	Environmental Services Dir. Date of Compliance: 1/2/2024	

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F 677	Continued From page 17 she turned the call light on as soon as she got in on 12/2/23 at around 9:30 AM and noticed the resident had wet her brief and had a bowel movement. After an hour, she got up and walked up and down the hallway looking for a staff to assist her but did not see anybody. She stated she found the nurse in the other hallway and asked her to help. The family member stated she turned the call light off when she went back to the resident's room with the nurse. She stated Resident #66 was detuned because of her condition and would not be able to communicate if she was wet or had a bowel movement. She stated on 12/3/23, she did not turn the call light on and just sent a message through the staff passing out ice that she needed assistance with cleaning up Resident #66. During an interview on 12/6/25 at 5:00 PM, the Director of Nursing stated the staffing numbers on the weekends were not different on any other day. There were no ancillary staff during the weekends to help with answering the call lights. The nurse and the nurse aide were responsible for answering the call lights on the weekends and assist residents with their needs such as changing their brief. She also stated her goal was to increase staffing.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		1/2/24

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F 686	Continued From page 18 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to provide pressure ulcer care per physician orders for 1 of 4 residents (Resident #94) reviewed for pressure ulcers. The findings included: Resident #94 was admitted to the facility on 8/31/23 with diagnoses that included osteomyelitis (bone inflammation from infection) and sacral region stage 4 pressure ulcer (wound on the coccyx from prolonged pressure on the skin). A review of the wound providers' admitting Assessment dated 9/1/23 indicated Resident #94 had an existing stage 4 pressure ulcer on the coccyx area that measured 2.9 centimeters (cm) in length by 2.1 cm in width and 0.9 cm deep. The area had moderate serous drainage. The Admission Minimum Data Set (MDS) on 9/2/23 indicated Resident # 94 was cognitively intact. She had a stage 4 pressure ulcer on her coccyx and was receiving wound care. She was at risk of developing pressure ulcers. She used pressure reducing devices on her bed and her chair. She required limited assistance with bed mobility and one person assist with bathing. She	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 The facility failed to provide a pressure wound treatment as ordered. 1. Immediate corrective action for resident(s) affected by the alleged deficient practice: On 12/3/2023 the medical director was notified and ordered dressing to be completed per order, wound was assessed by nurse and treatment was completed per order, RP and resident updated. 2. Corrective action for residents with	

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F 686	Continued From page 19 used a walker for mobility. She was always continent of bowel and bladder function. Resident #94's care plan dated 11/3/23 indicated she had a pressure ulcer to her coccyx area and was at risk for developing additional pressure ulcer due to decreased ability to reposition and incontinence. Interventions included administering treatments as ordered and monitoring for effectiveness. A review of the wound provider's note on 12/1/23 indicated the area on coccyx is 2.1 cm in length x 1.5 cm in width and 0.5 deep with moderate serous dressing. No necrosis noted. A review of physician order dated 12/1/23 for wound care stated to clean the coccyx wound with normal saline or wound cleanser, pat dry, apply collagen to wound bed, cover with gauze, secure with a silicone bordered dressing daily on day shift for wound care. A review of Resident #94's Treatment Administration Record (TAR) for December 2023 indicated the treatment order for Resident #94 for 12/2/23 and 12/3/23 were initialed by Nurse #1 indicating the wound care was performed. During an interview on 12/3/23 at 3:44 PM, Resident #94 stated the nurse did not change the wound dressing on her coccyx on 12/2/23. She stated it was supposed to be changed every day, but the nurses skipped some days. During an observation of Nurse #4 perform the wound dressing on Resident #94's coccyx on 12/4/23 at 3:01 PM, it was noted that the wound was approximately 2 cm long, 1.5 wide and 0.5	F 686	the potential to be affected by the alleged deficient practice. All residents in the facility with wound care orders have the potential to be affected. Beginning on 12/22/2023 the Wound Nurse began auditing all residents with pressure ulcers to assure that the most current treatment order was in place and being provided as ordered. Results: 10 of 10 residents with pressure ulcers had an accurate treatment order in place as recommended by the physician/wound physician with an accurately dated dressing. This audit was completed as of 12/22/2023 and all residents with pressure ulcers were in compliance. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 12/21/2023 the Staff Development Nurse began in-service education to all full time, part time, and as needed and agency nurses this training completed on 12/29/2023 and topics included: " Completing treatments as ordered and protocol if unable to complete. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	

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F 686	Continued From page 20 cm deep with a minimal amount of thick brownish drainage. The surrounding areas were pink and did not have a noticeable odor. During an interview on 12/5/23 12:15 PM, Nurse #1 stated Resident #94 wanted her wound care done first thing in morning. She stated she changed the resident's dressing on her coccyx on both Saturday (12/2/23) and Sunday (12/3/23). Nurse #1 described the pressure ulcer as "a little tinee tiny hole" and that the order was for silver alginate dressing then changed to calcium alginate with foam dressing. She stated the wound on resident's coccyx looked like a tiny pin hole. Nurse #1 explained the resident stood up during dressing changes and assistance of another staff member was not needed for the dressing change. During a follow up interview on 12/6/23 9:30 AM, Resident #94 stated she did not refuse her dressing on Saturday (12/2/23). She stated the nurse never came back after she gave her medications. During an interview on 12/6/23 at 10:30 AM, Nuse Aide (NA) #1 stated on 12/3/23 Resident #94 told her the nurse did not do her dressing change on 12/2/23. She had not seen Nurse #1 do any treatments on 12/2/23 and she never came to get her to help with dressing changes for any residents. NA #1 stated some residents needed two staff for the nurse to change dressings on their buttocks or to apply treatment. She stated Resident #94 stood up during dressing changes to her coccyx. During an interview on 12/6/23 at 5:00 PM, the Director of Nursing (DON) revealed Resident #94	F 686	process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing, and/or designee will utilize the QA tool for Pressure Ulcer Prevention and Treatment to monitor compliance with the Pressure Ulcer Wound Care monitoring tool. Monitoring began 12/27/2023. The Director of Nurses, and/or designee will monitor five residents with pressure ulcers weekly for 2 weeks, then monthly for 3 months for accuracy of wound treatment completion. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Therapy Manager, Activities Director, Social Worker, Environmental Services Director.	

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F 686	Continued From page 21 was cognitively intact and could verbalize what had occurred or not. She stated the resident could tell you if her dressings were changed or not. She stated the agency nurses do not just pass medications. They were supposed to do treatments as well.	F 686	Date of Compliance: 1/2/2024	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		1/2/24

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F 725	Continued From page 22 Based on record review, observations, and staff interviews, the facility failed to provide sufficient nursing staff to assist a resident with incontinence care for 1 of 6 residents reviewed for staffing (Resident #66). The findings included: This tag was cross-referenced to: F550 - Based on record review, family and staff interviews, the facility failed to maintain a resident's dignity by not providing assistance to a resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 7 residents reviewed for dignity. The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity and not having to wait for incontinence care after having a bowel movement. F677 - Based on record review, observation, family and staff interviews, the facility failed to provide incontinence care to a dependent resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 6 residents reviewed for activities of daily living. A review of the Centers for Medicare and Medicaid Services (CMS) payroll-based journal (PBJ) staffing data revealed the facility triggered excessively low weekend staffing levels for all four quarters for the fiscal year 2023. During an interview on 12/4/23 at 9:30 AM, Nurse #4 indicated staffing in the facility comes and goes. He stated they were staffed well with nurses, but they call in sick. The Director of	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F725 - SUFFICIENT STAFFING: 1. Corrective action for affected residents. A corrective action was obtained for resident #66 on 12/3/2023 when staffing levels were increased. Call bell was answered and care was performed on 12/3/2023. Corrective action for potentially affected residents. On 12/22/2023, a 100% review of staffing ratios, assignments and current temporary agency staff use was completed by the Director of Nursing (DON), and ADON for the period of 12/1/23 to 12/22/23. On 12/22/2023, the DON also reviewed the staffing plan for call ins to assure a system was in place for obtaining fill in staff. The review revealed facility staffing sufficient for the facility based on ratios and acuity. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 725	Continued From page 23 Nursing, Assistant Director of Nursing and the Nurse Manager helped run the medication carts. During an interview on 12/5/23 at 9:00 AM, Nurse Aide (NA) #4 stated she usually had 18 to 20 residents by herself. She felt terrible for the residents because they do not receive the care they deserve. They do not get turned, showered properly, and do not receive care in general. She also stated she was showering a resident, and she came out to angry family members and residents because they had their call lights on for a long time. She stated she called for help over the radio for help with the lift, but nobody came. She heard another nurse aide kept her radio off because the nurse aide did not have time to help. She was only able to complete a resident shower one per day instead of two. During an interview on 12/6/23 at 0910, NA #3 stated she was assigned to 18 or 20 residents most of the time depending on the hallway and who showed up to work. She stated some days were hard and she did her best to provide care as much as she can. She stated she had some residents that were aggravated because their call light was on for a while, and she was busy attending to somebody. She stated the facility did not have enough staff, but they had good staff and she had good experience so far. During an interview on 12/6/23 at 10:20 AM, NA #1 stated they were short of staff. Sometimes she worked double shift twice a week to help. She stated she had an average of 24 residents each shift and only had three nurse aides that worked the other hallways. She stated she did not have time to provide all the care the residents needed when she had 24 residents. She only got to do	F 725	deficient practice. No corrective action was required for residents. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: Systemic changes On 12/22/2023, the DON & SDC began an in-service education to all full time, part time, agency and as needed licensed nurses (RN, LPN), Medication Aide and certified nurse aide (CNA). Topics included: " The importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. " The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL and Assessment needs of the residents. " Educate scheduler related to call outs and who to report callouts to, to ensure proper staffing ratios The Director of Nursing will ensure that any Licensed Nurse, Medication Aide or CNA who has not received this training by 12/29/2023 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the	

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F 725	Continued From page 24 rounds twice a shift only. She had residents or family members tell her their call lights had been on for a long time. She stated she could not answer the call light if she was attending to other residents in their room. Nobody else was out on the hallway to check on the other residents. She stated there were three agency nurse aides and a regular nurse aide each day. Some nurse aides were not getting residents up because they did not have anybody to help them. They did not have regular staff that knew these residents. The facility just recently closed F hall because management knew they were short-staffed. She stated they had to complete 1 to 2 showers a day, but it was hard if nobody was there to help with transfers or with lifts. She stated the residents got wiped down with wipes and did not have a real bed bath. She stated she tried talking to the nurse manager and made them aware of what was going on. During a telephone interview on 12/06/23 at 11:48 AM, NA #2 stated staffing was pretty good. The facility had a lot of agency staff. She said sometimes there were four to five nurse aides for the day shift. NA #2 said on a really bad day, they only had three and this happened once every 4 months. There were a few times when some residents complained about having to wait a long time for staff to answer call lights. During a telephone interview on 12/06/23 at 12:02 PM, NA #5 stated staffing was okay, but it could be a lot better. The number of resident assignments depended on the staffing. She had 16 if they had enough staff but she has had up to 25 residents. NA #5 stated it was more normal having 25 residents assigned to her than 16 residents. She stated she tried to do two to three	F 725	required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Licensed Nurses, Medication Aides, and CNA□s who give residents care in the facility. Additionally, Facility currently entered into contract with three staffing agencies to ensure sufficient staff available to meet the needs of residents. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality Assurance Beginning 12/26/2023, The Director of Nursing/ designee will monitor this issue using the Survey Quality Assurance Tool for Sufficient Staffing. The review will consist of reviewing staffing ratios and assignments to include reviewing for any grievance reports related to staffing from previous day 3 x a week for 4 weeks then monthly x 2 months or until resolved. Interventions will be implemented as appropriate to ensure sufficient staffing coverage is sustained. Reports will be given to the weekly Quality Assurance committee and corrective action initiated as appropriate. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, MDS	

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incontinence rounds. If there were multiple call lights, she would pop in and tell the residents that she was assisting another resident, but she would come back. NA #5 stated that she turned the residents' call lights off once she informed them that she would be back. She stated some residents had complained to her about other shifts not answering their call light immediately but not on her shift.

During an interview on 12/05/23 at 4:45 PM, the Scheduler stated she went by the daily census when scheduling staff on all shifts. She stated there were four nurses and a medication aide or five nurses on first and second shift. She stated she would like to have 5 or 6 nurse aides for a census of 100 on first and second shift. She stated the facility had that number of nurse aides by using agency staff. Nurse staffing was a challenge and having agency nurses helped. The nurse managers also helped on the floor working as needed. The Scheduler stated she knew how short they were but tried to staff the halls with who was best at knowing and meeting the residents' needs. The Scheduler stated they had open positions for nurses, nurse aides and medication aides on both the first and second shift. The Scheduler stated it was easier to schedule for the weekend because there were more staff that could work the weekends. She stated the third shift was well staffed with four nurse aides and two nurses in the building for a census of 100. If there were call outs, the nursing supervisors assist in calling staff in and the Scheduler tried to contact agencies for any available staff.

During an interview on 12/5/23 at 3:53 PM, the Director of Nursing (DON) stated she reviewed

Coordinator, Rehab Manager, Activities Director, Social Worker and Environmental Services Director.

Date of compliance: 1/2/2024

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and approved the schedules completed by the Scheduler. She stated the schedule was based on daily census. One nurse can have up to 28 residents. The number of nurses in the rehabilitation hall (K Hall and top half of S) varied. She stated F Hall was empty to accommodate short staffing. The DON stated they did not stop admissions and had two more residents that came in that week. She stated they usually have a nurse and a medication aide for the rehabilitation area due to higher acuity and daily skilled nursing documentation. The DON explained the weekend staffing was the same as the weekdays. If somebody called in, nursing management called other nurses to come in or asked agencies for nurses. She stated they would be severely short-staffed without agency staff. Her goal was to reduce shortage. The facility posted job vacancies on the internet. Corporate also sent them applications they received from their website. The DON stated they raised the nurse wages and just recently created part time positions and increased hourly wage for part timers. The goal was to get them to stay and work part time. She stated the nurse managers covered the floor and were ready to help as needed. The common complaint that the residents and their families brought to her attention was related to low staffing. The DON stated they talked individually to them about their recruitment efforts and what they were doing. They had a hall closed and were being careful not to overfill the building and not have enough staff to accommodate the residents' needs. Human Resources and nursing management also talked to staff that were quitting to see what the issues were. Most of their reason was their need for more education. She stated they never had low staff on weekends because they staffed the same

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F 725	Continued From page 27 as every other day. They found staff to cover if there were sick calls. The DON stated the weekends feel short-staffed to residents and families since ancillary staff were not in the facility. During a follow-up interview on 12/6/23 at 5:00 PM, the Director of Nursing (DON) stated her goal was to increase staffing. She stated the facility would not have enough staff without the agencies. During an interview on 12/6/23 at 7:00 PM, the Administrator stated the facility had the same number of staff scheduled 7 days a week. If they did not have enough staff, then they filled them with agency staff. The department heads rotated to work 4 hours every weekend and had to be present during mealtimes. They also answered call lights when they are in the building during the weekends, but they were not primarily responsible for answering call lights. The Administrator stated she thought there were enough staff to meet the residents' needs during the weekends. She stated staffing was based on census and they were scheduling the same number of staff 7 days a week.	F 725		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		1/2/24

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F 761	Continued From page 28 §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 label an open vial and discard expired medications in 2 of 10 medication carts (Sinclair 2 and Carlton 2 medication carts), and secure 1 of 10 medication carts (Ashworth medication cart). The findings included: 1.a. An observation of the Sinclair 2 medication cart on 12/6/23 at 2:37 PM with Nurse #2 revealed an open and unlabeled vial of Lidocaine and an Insulin Lispro pen with an open date of 9/16/23. A sticker was attached to the insulin pen that indicated to discard after 28 days of opening. Both medications were available for use in the top drawer of the medication cart. During the observation, an interview with Nurse #2 revealed the open vial of Lidocaine was not currently being used because it had been used to dilute an	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Immediate corrective action for medication carts affected by the alleged deficient practice: Sinclair # 2 medication cart, the unlabeled	

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F 761	Continued From page 29 antibiotic and the antibiotic had been discontinued. Nurse #2 stated that the Insulin Lispro pen had also been discontinued and that it expired after 28 days of opening. Nurse #2 also stated that both medications should have been discarded but that she did not notice them when she administered medications from the medication cart that morning. She further stated that the nurses should check the medications in the medication carts when they had time to do so. b. An observation of the Carlton 2 medication cart on 12/6/23 at 3:19 PM with Nurse #3 revealed an open bottle of Geri-Lanta available for use in the middle drawer and it was marked with a manufacturer's expiration date of 10/23. (Geri-Lanta is an antacid, anti-gas oral suspension containing alumina, magnesia, and simethicone.) Nurse #3 stated she had just received report from the outgoing nurse. Nurse #3 who was an agency nurse stated she was not sure about the facility's procedure regarding who was assigned to check the medications in the medication carts. She stated that she knew the night shift nurses were assigned to clean the medication carts, but all the nurses should be accountable for discarding expired medications. An interview with the Director of Nursing (DON) on 12/6/23 at 5:17 PM revealed the expired medications in the medication carts should have been discarded and the open vial of Lidocaine should have been labeled. The Lidocaine vial was supposed to be used for just one resident. The DON stated that the charge nurses and the unit managers including herself looked at the medication carts periodically. The nurses were responsible for each medication cart whenever they had them. In addition, the plan was for the	F 761	Lidocaine, discontinued and the expired insulin pen of a discharged resident were removed and discarded from the cart on 12/6/2023 by the Director of Nursing (DON). Carlton #2 medication cart, the expired Geri-Lanta was removed and discarded from the cart on 12/6/2023 by the DON. Ashworth medication cart, the unlocked cart out of staff view was locked on 12/4/2023 by the DON who observed it unlocked. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 12/6/2023, Staff Development Coordinator (SDC) initiated education regarding labeling medication, monitoring for expired medications and keeping medication carts locked this was completed on 12/29/2023. Assistant Director of Nurses (ADON), and SDC audited all medication carts; identified any expired or unlabeled medications. Corrections were made immediately where indicated. This was completed on 12/22/2023. Medication room audited for expired medications on 12/27/2023. All medications observed as current.	

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F 761	Continued From page 30 night shift nurse to check the medication carts weekly. 2. During the observation of Ashworth Hall on 12/4/23 from 8:33 AM to 8:55 AM the medication cart was unlocked. The cart was left unlocked across from the common area on Ashworth Hall. During this time the nurse assigned to the Ashworth Hall medication cart was not around the medication cart and it was later revealed that she was now using a different medication cart on the Carlton Hall. During this time no residents passed the unlocked cart, however staff were observed passing the unlocked cart. At 8:55 AM the Director of Nursing passed the cart and locked it and kept walking down the hall. An interview with the Director of Nursing (DON) on 12/4/23 at 8:55AM revealed that she did lock the cart and confirmed that the medication cart should have been locked. An interview with Nurse #2 on 12/4/23 at 9:00 AM revealed that she was assigned to administer medications on the Ashworth Hall, back of Carlton Hall, and Ellicott Hall. The nurse stated that she must have forgotten to lock the cart after administering the medication. The nurse stated she gave the medication right around 8:30 AM. After administering the medication she went to Carlton Hall to start administering medications using the medication cart for Carlton Hall.	F 761	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 12/21/2023, the DON, ADON and SDC began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff which completed on 12/29/2023 on the following topics: " Checking medications for expiration date and discarding promptly. " Labeling medications when opened with date and resident name and discarding when the treatment is complete or with resident discharge as indicated. " Pharmacy recommended storage for selected items. " Securing medication carts. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 761	Continued From page 31	F 761	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON, ADON and SDC will monitor compliance utilizing the F761 Monitoring Tool beginning 12/26/23 for Medication Cart Security/ Expired and Discontinued Medications/ Medications Labeled Appropriately weekly x 4 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling medications with a date when opened; labeling multi-use vials with resident□s name and medication cart security. This monitoring will consist of monitoring all medication/ treatment carts, and medication rooms weekly by DON or designee. Reports will be presented to the weekly Quality Assurance committee by the DON or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The Quality Assurance Committee Members are: The Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, Therapy Manager, Activities Director, Social Worker and Environmental Services Director. Date of Compliance: 1/2/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		1/2/24

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F 812	Continued From page 32 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired food stored for use in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer and the dry goods storage room and failed to date perishable food stored for use in the walk-in cooler. This practice had the potential to affect food served to residents. The findings included: During the initial tour of the kitchen on 12/03/23 from 9:30 AM to 9:45 AM an observation with the Assistant Dietary Manager of the walk-in cooler revealed the following: - 1 opened, ½ used bag of hashbrown with no date - whole bag of hashbrowns with no date -1 medium sized bag of baby sized carrots expired packaged date of 10/10/23	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 12/03/2023. During initial walk through of the kitchen on 12/03/2023, it was noted dietary services had failed to properly label, date,	

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F 812	Continued From page 33 -1 5-pound bag of shredded cheese expired packaged date of 11/27/23 An observation with the Assistant Dietary Manager of the walk-in freezer at 9:45 AM revealed the following problem: -1 cooked casserole with expired written date to use by of 11/21/23 -1 cooked vanilla cake with expired written date to use by of 11/23/23 -1 cooked chocolate cake with no date -1 opened, bag of breaded shrimp with no date -1 clear extra-large reusable plastic bag labeled chicken salad expired written date to use by of 10/24/23 -1 whole bag of hushpuppies expired packaged date of 10/15/23 -1 clear large reusable plastic bag of hot dogs expired written date to use by of 10/08/23 -1 clear large reusable plastic bag of hot dogs expired written date to use by of 11/05/23 -1 white container of hot dog chili expired packaged date of 10/08/23 -1 cooked pan of hot dog chili expired written date to use by of 11/23/23 -1 bag of queso dip expired packaged date of 09/20/23 -1 opened, box of vegetable hot dogs expired packaged date of 11/21/23 -1 opened, box of vegetable sausages expired packaged date of 11/21/23 -4 clear extra-large reusable plastic bags labeled diced chicken expired written date to use by of 01/03/23 An observation with the Assistant Dietary Manager of the dry storage room at 10 AM revealed the following problem: -Eight- 33.8 fluid ounce bottles of Glucerna	F 812	store, and discard expired food items in the walk cooler, walk-in freezer, and dry good storage area. On 12/03/2023 the Assistant Dietary Manager and Dietary Manager discarded all items cited. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/19/2023, the Senior Nutrition Service Coordinator completed an end of year inventory, organization, and review of all storage areas in the kitchen to ensure all food items were within their dates and dated properly. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 12/19/2023 by Senior Nutrition Service Coordinator. Topics included: " Storage and dating policy. " Shift inspections to observe all food are within their dates and tossed if out of date. " Use by Dates of common food items and where to find use by dates. Inspections on each shift to review all storage areas to ensure all food is labeled, dated, and stored properly. Food items left in original boxes when received from truck to better track dates. Use by Date Posters posted to storage areas.	

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F 812	Continued From page 34 expired packaged date of 12/01/23 -Seven- 28-ounce bags of chocolate pudding mix expired packaged date of 12/13/22 -Six- 8.75-ounce bags of chocolate pie filling mix expired packaged date of 03/21/23 The Assistant Dietary Manager observed on 12/03/23 at 9:30 AM the food stored inside of the walk-in cooler, walk-in freezer, and dry storage room that were unsealed and expired. She revealed the process for food storage was making sure all foods were sealed, labeled, and dated with a opened date and discard date. She verbalized all food dates should be checked by all dietary staff on a regular basis and any expired foods should be properly discarded. She indicated she would have the food items discarded. An interview with the Dietary Manager on 12/03/23 at 10:30 AM revealed all food items should be sealed, labeled, and dated when being stored. He stated should be checking food items on a regular basis and discarding any items that are not sealed, labeled, dated, or have expired immediately. An interview with the Corporate Registered Dietician (RD) on 12/04/23 at 11:04 AM revealed staff should make sure all open food containers were labeled, sealed, dated, and any expired food items should be removed and properly discarded. An interview with the Administrator on 12/06/23 at 6:16 PM revealed all food containers should be labeled, sealed, dated, and expired foods should be discarded immediately.	F 812	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or assignee will monitor procedures beginning 12/19/23 for proper food storage weekly x 4 weeks then monthly x 2 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 1/2/2024	
F 867 SS=E	QAPI/QAA Improvement Activities	F 867		1/2/24

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F 867	Continued From page 35 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 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	F 867		

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F 867	Continued From page 36	F 867		

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.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms

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F 867	Continued From page 37 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: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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F 867	Continued From page 38 interventions the committee put into place following the recertification survey conducted on 6/10/22. This was for seven repeat deficiencies that were originally cited during the recertification and complaint survey on 6/10/22 and were subsequently recited during the recertification and complaint survey on 12/6/23 in the areas of resident rights/exercise of rights, accuracy of assessments, coordination of PASRR and assessments, activities of daily living care provided for dependent residents, treatment or services to prevent/heal pressure ulcers, sufficient nursing staff, and food procurement. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F550 - Based on record review, family and staff interviews, the facility failed to maintain a resident's dignity by not providing assistance to a resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 7 residents reviewed for dignity. The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity and not having to wait for incontinence care after having a bowel movement. During the recertification and complaint investigation survey conducted on 6/10/22, the facility failed to maintain resident's dignity when there was a delay in answering their call light when toileting/incontinence care was needed, not providing showers/bathing assistance as	F 867	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/27/2023, the Administrator educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program, the purpose of the QA program, monitoring outcomes and identifying and maintaining desired results. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of deficiencies cited during the December 6th survey for f tags 550, 641,644, 677, 686, 725, and 812. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 12/27/2023 to review the deficiencies from the Dec 3 to Dec 6 recertification and complaint survey and reviewed the citations. 3. Measures/Systemic changes to prevent	

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F 867	Continued From page 39 scheduled and not providing assistance out of bed when requested resulting in residents feeling "dirty, mad, isolated and forgotten about." F641 - Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of cognitive patterns, mood, behavior and participation in assessment and goal setting for 2 of 6 residents (Resident #57 and Resident #11) whose MDS were reviewed. During the recertification and complaint investigation survey conducted on 6/10/22, the facility failed to accurately code Minimum Data Set assessments in the areas of wandering behavior, pressure ulcers, discharge, and restraints. F644 - Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II was completed after new mental health diagnoses for 2 of 3 residents (Resident #37 and #39) reviewed for PASRR. During the recertification and complaint investigation survey conducted on 6/10/22, the facility failed to request a Preadmission Screening and Resident Review (PASRR) for a resident with a new mental health diagnosis. F677 - Based on record review, observation, family and staff interviews, the facility failed to provide incontinence care to a dependent resident (Resident # 66) with a soiled brief when requested by a family member for 1 of 6 residents reviewed for activities of daily living. During the recertification and complaint investigation survey on 6/10/22, the facility failed to provide showers or bed baths as scheduled for	F 867	reoccurrence of alleged deficient practice: Education: On 12/27/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Assistant Dir of Nursing, Staff Development Nurse, Minimum Data Set Coordinator, Therapy Manager, Activities Dir, Social Worker and the Environmental Service Dir on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of f tags 550, 641, 644, 812, 686, 677 and 725. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 12/28/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance beginning 12/27/23 utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will	

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F 867	Continued From page 40 residents. F686 - Based on observation, record review, and interviews with resident and staff, the facility failed to provide pressure ulcer care per physician orders for 1 of 4 residents (Resident #94) reviewed for pressure ulcers. During the recertification and complaint investigation survey conducted on 6/10/22, the facility failed to complete weekly skin assessments for residents with pressure ulcers. F725 - Based on record review, observations, and staff interviews, the facility failed to provide sufficient nursing staff to assist a resident with incontinence care for 1 of 6 residents reviewed for staffing (Resident #66). During the recertification and complaint investigation survey conducted on 6/10/22, the facility failed to maintain sufficient nursing staff to ensure a resident was not left lying in a soiled brief while waiting for staff to respond to an engaged call light for incontinence care. The facility failed to ensure requests from a resident dependent on staff for transfer was not left in bed after multiple requests to get out of bed. The facility failed to ensure residents dependent on staff to provide physical assistance with bathing received showers as scheduled. F812 - Based on observations and staff interviews, the facility failed to remove expired food stored for use in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer and the dry goods storage room and failed to date perishable food stored for use in the walk-in cooler. This practice had the potential to affect food served to residents. During the recertification and complaint investigation survey on 6/10/22, the facility failed	F 867	monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the accident process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, MDS Coordinator, Therapy Manager, Staff Development Coordinator. Activities Dir, Social Worker, and Environmental Services Dir. Date of Compliance: 1/2/2024	

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F 867	Continued From page 41 to ensure kitchen equipment was kept clean by not removing a buildup of debris from an ice machine. During an interview on 12/6/23 at 7:00 PM, the Administrator stated she was surprised that they were still having concerns with all these areas. She stated these were addressed previously with Performance Improvement Plans, especially with showers as part of their Quality Assurance process. She stated they monitored compliance with the plan of correction after the last survey. The call lights were also a part of their Quality Assurance and Performance Improvement program. The Administrator presented PIP on adequate nursing staffing and call light response time. No other follow up on record was provided once target goals were met on 5/31/23 for both areas.	F 867		