STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/28/2023 through 12/01/2023. The faciltiy was found in compliance with the requirement CFR 483.75, Emergency Preparedness. Event ID # 2H2N11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/28/2023 through 12/01/2023. Event ID #2H2N11. The following intakes were investigated NC00201690, NC00203302, NC00204324, NC00204762, NC00205806, NC00206542, NC00206552, NC00207198, and NC00209032. 1 of 26 complaint allegations resulted in a deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		12/18/23

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

Electronically Signed | 12/19/2023

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F 623	Continued From page 1	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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F 623	Continued From page 2 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing	F 623	The Plan of correction is not to be construed as an admission of any	

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F 623	Continued From page 3 of the residents transfer to the hospital for 2 of 4 residents reviewed for hospitalization (Resident #2 and Resident #86). The findings included: 1. Resident #2 was admitted to the facility on 3/09/20. Review of the nursing progress note dated 10/28/23 at 16:21 revealed resident #2 was transferred to the hospital. Resident #2 was transferred to the hospital on 10/28/23 and returned to the facility on 10/31/23. Record review of the progress notes revealed there was no documentation that the Ombudsman was notified of Resident #2's transfer to the hospital on 10/28/23. An interview was conducted on 11/29/23 at 4:05 pm with the Social Worker who revealed she was new to the position as of September 2023 and was not aware she was required to notify the Ombudsman of Resident #2's transfer to the hospital. The Social Worker stated she was trained by the previous Social Worker, but the Ombudsman notification of transfer was not included in the training she received. Attempts to interview the previous Social Worker on 11/29/23 at 4:43 pm, 11/30/23 at 12:03 pm, and 11/30/23 at 3:12 pm were unsuccessful. During an interview with the Administrator on 12/01/23 at 10:04 am she revealed the Social Worker was responsible to notify the Ombudsman of Resident #2's transfer to the hospital. The Administrator stated she was not	F 623	wrongdoing or liability. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F623 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Social Work Director provided written notification regarding transfer of Resident #2 (hospital transfer 10/28/23), Resident #86 (Hospital transfer 09/22/23 & 10/10/23) provided to the ombudsman. The Social Work Director notified the Ombudsman's office that they would be sending regular updates. for facility transfers/discharges. All discharges/transfers since September,	

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F 623	Continued From page 4 aware that the Social Worker was not trained to notify the Ombudsman of resident transfers. 2. Resident #86 was admitted to the facility on 9/12/22. The nursing progress note dated 9/22/23 at 2:40 am revealed Resident #86 was transferred to the hospital. Resident #86 was transferred to the hospital on 9/22/23 and returned to the facility on 9/29/23. The nursing progress note dated 10/19/23 at 3:00 pm revealed Resident #86 was transferred to the hospital. Resident #86 was transferred to the hospital on 10/19/23 and she did not return to the facility. Review of Resident #86's progress notes revealed there was no documentation that the Ombudsman was notified of the transfers to the hospital on 9/22/23 or 10/19/23. An interview was conducted on 11/29/23 at 4:05 pm with the Social Worker who revealed she started at the facility in September 2023 and was new to the position. The Social Worker stated she was not aware she was required to notify the Ombudsman of Resident #86's transfers to the hospital. The Social Worker stated she was trained by the previous Social Worker, but the Ombudsman notification of transfer was not included in the training she received. Attempts to interview the previous Social Worker on 11/29/23 at 4:43 pm, 11/30/23 at 12:03 pm, and 11/30/23 at 3:12 pm were unsuccessful. During an interview with the Administrator on	F 623	2023 provided to the ombudsman via email. 2. Address how the facility will identify other residents having the potential to be affected the same deficient practice: On 12/15/23 Social Work Director received education by the facility Administrator regarding notification of the Ombudsman and of all residents being transferred and/or discharged from the facility. All notifications of discharges/transfers from the facility will be provided via email. Documentation of the notification to the ombudsman will be entered in the resident chart. 3. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Beginning 12/18/23 The SSD and/or administrator will audit all discharges weekly x 12 weeks utilizing the discharge/transfer notification audit tool, to ensure all appropriate parties (ombudsman & RP) have been notified and documentation has been entered into the resident's chart. The administrator will address all deficiencies identified immediately for resolution. 4. Indicate how the facility plans to monitor its performance to make sure that Compliance is sustained: The results of the audits will be forwarded to the facility QAPI committee x 3 months to determine the need for further intervention or compliance has met.	

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F 623	Continued From page 5 12/01/23 at 10:04 am she revealed the Social Worker was responsible to notify the Ombudsman of Resident #86's transfers to the hospital. The Administrator stated she was not aware that the Social Worker was not trained to notify the Ombudsman of resident transfers.	F 623	Completed: 12/18/23	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Gradual Dose Reduction, insulin administration, and antipsychotic medication for 3 of 26 sampled residents (Resident #57, Resident #61, and Resident #58). Findings included: 1. Resident #61 had been readmitted on 9/8/22. Her diagnoses included Cerebrovascular Accident (CVA) and anxiety. A Psychiatric Nurse Practitioner note regarding Resident #61 dated 12/20/22 included diagnoses of anxiety and schizoaffective disorder. The consultant Pharmacist Recommendation to Physician form dated 4/7/23 included a note written by the physician dated 4/25/23 "Patient stable at currant dosage, any attempted GDR might cause decompensation." Review of Resident #61's October and November	F 641	F641 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/1/23 Resident #1 MDS assessment was accurately coded for GDR recommendations. On 12/1/23 Resident # 57 MDS assessment was accurately coded for administration insulin administration. On 12/1/23 Resident #58 MDS assessment was accurately coded for administration of antipsychotic medication injection. 2. Address how the facility will identify other residents having the potential to be affected the same deficient practice: On 12/11/23 The regional MDS coordinator educated the MDS nurses on coding MDS assessment accurately per RAI guidelines. Newly hired MDS staff will be educated during orientation by Regional MDS Consultant or designee on	12/18/23

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F 641	Continued From page 6 2023 Medication Administration Records were reviewed and revealed she received olanzapine (antipsychotic medication to treat the symptoms of schizophrenia) 7.5 milligrams twice daily. Resident #61's most recent quarterly Minimum Data Set (MDS) assessment dated 11/03/23 included diagnoses of anxiety, psychotic disorder, and schizophrenia. She received antipsychotic medication on a routine basis. No Gradual Dose Reduction (GDR) had been noted as attempted and no physician documentation of GDR as clinically contraindicated was noted. During an interview on 11/30/23 at 11:50 AM with the Corporate Consultant, she stated the MDS Nurses had access to pharmacy recommendations and physician documentation needed for information for the MDS assessments. She explained the MDS Nurses could look in the Medical Records department for forms not yet scanned into the system. She stated the MDS should be accurate and include correct information. On 11/30/23 at 12:05 PM an interview was conducted with MDS Nurse #1 and MDS Nurse #2. MDS Nurse #1 stated she reviewed physician notes and pharmacy records available in the electronic medical record. She stated she could check with medical records for things which were waiting to be scanned but clarified she would not look through the papers in there. 2. Resident #57 was admitted on 3/29/23. His diagnoses included diabetes. Review of Resident #57's August 2023	F 641	coding MDS assessment accurately. Effective 12/11/23 the MDS nurses conducted an audit of all resident MDS assessments for accurate coding of GDR/pharmacy recommendations, DMII/insulin administration, and psychiatric diagnoses and receiving antipsychotic medications. 3. The measures the facility will take to ensure the problem will be corrected and will not reoccur: Beginning 12/18/23 The MDS nurses will audit all newly admitted resident charts and 5 current resident charts weekly for accurate MDS assessment coding x 12 weeks, utilizing the MDS coding audit tool. The administrator will be notified immediately of any deficiencies to be resolved. 4. Indicate how the facility plans to monitor its performance to make sure that Compliance is sustained: The results of the audits will be forwarded to the facility QAPI committee x 3 months to determine the need for further intervention or compliance has met.	

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F 641	Continued From page 7	F 641		

Medication Administration Record revealed he received dulaglutide (a non-insulin diabetic medication) 0.75 milligram injection once weekly on Thursdays.
Resident #57's most recent quarterly Minimum Data Set (MDS) assessment dated 8/27/23 indicated he received one dose of insulin.

On 11/30/23 at 11:50 AM an interview with the Corporate Consultant was conducted. She explained the MDS should be accurate and include the correct information.

An interview was conducted on 11/30/23 at 12:07 PM with MDS Nurse #1. She stated the dulaglutide should not have been marked as insulin and this was an error.

3. Resident #58 was admitted to the facility on 3/31/22 with diagnoses which included schizophrenia.

A physician order dated 6/15/23 for Paliperidone Palmitate ER (an antipsychotic medication) prefilled syringe 234 milligrams (mg). Inject 234 mg one time a day every 28 days for antipsychotic.

Review of the nursing progress notes revealed Resident #58 received the antipsychotic medication injection on the following dates 6/26/23, 7/25/23, 8/22/23, 9/18/23, and 10/17/23.

The Minimum Data Set (MDS) quarterly assessment dated 10/27/23 revealed Resident #58 was coded as an antipsychotic medication was not received.

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F 641	Continued From page 8 During an interview on 12/01/23 at 8:54 am with the MDS Nurse #1 who revealed she did not recall seeing nursing progress notes that the medication was administered. The MDS Nurse #1 stated Resident #58 should have been coded for an antipsychotic medication during the last assessment period. An interview was conducted on 12/01/23 at 8:58 am with the MDS Nurse #2 who revealed when she completed the assessment, she would review the medication administration record or nursing notes to confirm the medication was administered. The MDS Nurse #2 was unable to state how the antipsychotic medication was missed on the assessment for Resident #58. An interview was conducted on 12/01/23 10:46 am with the Director of Nursing (DON) who revealed the MDS Nurses were responsible to ensure Resident #58's antipsychotic medication was coded accurately. During an interview on 12/01/23 at 10:11 am with the Administrator revealed the MDS Nurse was responsible to accurately code Resident #58's medications. The Administrator stated if the MDS Nurse was uncertain if Resident #58's antipsychotic medication was administered she would expect the MDS Nurse to follow-up with the DON.	F 641		
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	F 644		12/18/23

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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.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to refer residents with a serious mental health diagnoses for a Preadmission Screening and Annual Resident Review (PASARR) level II screening for 2 of 4 residents reviewed for PASARR (Resident #51 and Resident #9).

The findings included:

1. Resident #51 was admitted to the facility on 3/02/23 with diagnoses which included anxiety, depression, and schizoaffective disorder.

The Minimum Data Set (MDS) quarterly assessment dated 11/9/23 revealed Resident #51 had severe cognitive impairment and did not have a PASARR Level II. Resident #51 was coded for mental health diagnoses which included schizophrenia, anxiety, and depression and he was not coded for behaviors.

F644/F645

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
1. Social Work Director submitted information for Preadmission Screening and Resident Review (PASARR) for a re-evaluation for resident #61 and resident #51 on 12/12/2023. On 12/13/2023 the Social SWD submitted information for PASARR for a re-evaluation for resident #57 and resident #9.
Address how the facility will identify other residents having the potential to be affected the same deficient practice:
2. On 12/12/23, the Social Work Director and Administrator initiated an audit of all residents to ensure each resident had current and accurate PASARR. The

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F 644	Continued From page 10 During an interview with the Social Worker on 11/29/23 at 3:32 pm she revealed Resident #51's PASARR Level I notice dated 10/13/21 did not list schizophrenia on his list of diagnoses. The Social Worker stated she was not at the facility when Resident #51 was admitted, and she had not reviewed his PASARR information because the diagnosis was in place at the time of admission. She stated a level II review should have been sent due to the schizophrenia diagnosis not being listed on Resident #51's PASARR level I notice. Multiple attempts to interview the previous Social Worker on 11/29/23 at 4:43 pm, 11/30/23 at 12:05 pm, and 11/30/23 at 3:12 pm were unsuccessful. An interview with the Administrator was conducted on 12/01/23 at 9:56 am revealed the previous Social Worker was responsible to ensure Resident #51's PASARR level I was reviewed and referred for a PASARR level II screen if the schizoaffective disorder was not listed on the original PASARR level I notice upon admission. 2. Resident #9 was admitted to the facility on 5/31/17 with a diagnosis of stroke. Review of Resident #9's active diagnoses revealed a diagnosis of adjustment disorder with mixed anxiety and depressed mood was identified on 2/20/23. The Minimum Data Set (MDS) annual assessment dated 10/04/23 revealed Resident #9 did not have a PASARR level II. He was coded for a diagnosis of psychotic disorder and was not coded for behaviors.	F 644	Administrator and Social Work Director will address all concerns identified during the audit will address all concerns identified during the audit to include submitting information for PASARR evaluations for any resident who does not have a current PASSAR, has an expired PASARR or who has a need for Level II PASARR review following changes in mental health status or newly Level II qualifying diagnosis. Audit will be completed by 12/15/2023. The measures the facility will take to ensure the problem will be corrected and will not reoccur: 3. On 12/11/2023 the Administrator initiated an in-service regarding PASARRs with the Admission Director, Social Work Director, & Minimum Data Set Nurse (MDS)with emphasis on referral for evaluation/re-evaluation of PASARR on admission, when PASARR expires, following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 12/13/2023. After 12/13/2023, any Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Will not be permitted to work until education has been completed. Indicate how the facility plans to monitor its performance to make sure that compliance is sustained: 4. The Social Work Director will review 10 resident charts to include new admissions weekly x 12 weeks then monthly x 1 month utilizing the PASARR Audit Tool. This audit is to ensure the resident has a current and accurate	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 11 During an interview with the Social Worker on 11/29/23 at 3:32 pm she revealed Resident #9's PASARR Level I notice dated 5/29/17 did not have any mental health diagnoses listed. The Social Worker stated she was not at the facility when Resident #9's new diagnosis of adjustment disorder with mixed anxiety and depressed mood was identified, and she had not reviewed his PASARR information because the diagnosis was in place when she started. The Social Worker stated a level II review should have been sent due to the mental health diagnosis not being listed on Resident #9's PASARR level I notice. Multiple attempts to interview the previous Social Worker on 11/29/23 at 4:43 pm, 11/30/23 at 12:05 pm, and 11/30/23 at 3:12 pm were unsuccessful. An interview with the Administrator was conducted on 12/01/23 at 9:56 am revealed the previous Social Worker was responsible to ensure Resident #9's PASARR level I was reviewed and referred for a PASARR level II screen when the adjustment disorder with mixed anxiety and depressed mood was identified.	F 644	PASARR. The Administrator will address all concerns identified during the audit to include referral for evaluation/re-evaluation of PASARR for any resident without a current PASARR, an expired PASARR or following changes in mental health status or newly Level II qualifying diagnosis. The Administrator will review the PASARR Audit Tool weekly for 12 weeks then monthly x 3 months to ensure all areas of concern are addressed to promote compliance. The results of the PASARR Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI Committee will meet monthly and review the PASARR Audit Tool to determine the need for ongoing monitoring or further intervention to ensure compliance. Completed: 12/18/2023	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 645		12/18/23

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F 645	Continued From page 12	F 645		

independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the

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F 645	Continued From page 13 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) after the initial approval for nursing home placement expired for 2 of 4 residents reviewed for PASRR (Resident #57 and Resident #61). Findings included: 1. Resident #57 was admitted on 3/29/23. His diagnoses included depression, and schizophrenia. Resident #57's Admission Minimum Data Set (MDS) assessment dated 4/4/23 indicated a Level II PASRR determination for intellectual disability. He was noted with severe cognitive impairment, and diagnoses included anxiety, depression, and schizophrenia. A Level II Preadmission Screening and Resident	F 645	F644/F645 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Social Work Director submitted information for Preadmission Screening and Resident Review (PASARR) for a re-evaluation for resident #61 and resident #51 on 12/12/2023. On 12/13/2023 the Social SWD submitted information for PASARR for a re-evaluation for resident #57 and resident #9. Address how the facility will identify other residents having the potential to be affected the same deficient practice: 2. On 12/12/23, the Social Work Director and Administrator initiated an audit of all	

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F 645	Continued From page 14 Review (PASRR) determination notice dated 2/08/23 indicated the determination had an expiration date of 4/09/23. No further PASRR determination notices were discovered for Resident #57. Multiple attempts to interview the previous Social Worker (SW) on 11/29/23 at 4:43 pm, 11/30/23 at 12:05 pm, and 11/30/23 at 3:12 pm were unsuccessful. An interview with the SW was conducted on 11/30/23 at 11:02 AM. She explained she had been in this only been in this position for a few months. She had just been made aware of the expired PASRR determination and had not yet been set up to access the PASRR program to check for information. During an interview with the Administrator on 11/30/23 at 11:17 AM she stated the PASRR determination should be up to date. 2. Resident #61 had been readmitted on 9/8/22. Her diagnoses included Cerebrovascular Accident (CVA) and anxiety. A Psychiatric Nurse Practitioner note regarding Resident #61 dated 12/20/22 included diagnoses of anxiety and schizoaffective disorder. A Level II Preadmission Screening and Resident Review (PASRR) determination notice dated 10/3/22 indicated the determination had an expiration date of 1/01/23. No further PASRR determination notices were discovered. Resident #61's most recent annual Minimum Data Set (MDS) assessment dated 8/07/23 indicated she had a Level II PASRR	F 645	residents to ensure each resident had current and accurate PASARR. The Administrator and Social Work Director will address all concerns identified during the audit will address all concerns identified during the audit to include submitting information for PASARR evaluations for any resident who does not have a current PASSAR, has an expired PASARR or who has a need for Level II PASARR review following changes in mental health status or newly Level II qualifying diagnosis. Audit will be completed by 12/15/2023. The measures the facility will take to ensure the problem will be corrected and will not reoccur: 3. On 12/11/2023 the Administrator initiated an in-service regarding PASARRs with the Admission Director, Social Work Director, & Minimum Data Set Nurse (MDS)with emphasis on referral for evaluation/re-evaluation of PASARR on admission, when PASARR expires, following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 12/13/2023. After 12/13/2023, any Admission Director, Social Worker, Minimum Data Set Nurse (MDS), Will not be permitted to work until education has been completed. Indicate how the facility plans to monitor its performance to make sure that compliance is sustained: 4. The Social Work Director will review 10 resident charts to include new admissions weekly x 12 weeks then monthly x 1 month utilizing the PASARR	

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F 645	Continued From page 15 determination for serious mental illness. She was noted with severe cognitive impairment, and diagnoses included anxiety, psychotic disorder, and schizophrenia. Multiple attempts to interview the previous Social Worker (SW) on 11/29/23 at 4:43 pm, 11/30/23 at 12:05 pm, and 11/30/23 at 3:12 pm were unsuccessful. An interview with the SW was conducted on 11/30/23 at 11:02 AM. She explained she had been in this only been in this position for a few months. She had just been made aware of the expired PASRR determination and had not yet been set up to access the PASRR program to check for information. During an interview with the Administrator on 11/30/23 at 11:17 AM she stated the PASRR determination should be up to date.	F 645	Audit Tool. This audit is to ensure the resident has a current and accurate PASARR. The Administrator will address all concerns identified during the audit to include referral for evaluation/re-evaluation of PASARR for any resident without a current PASARR, an expired PASARR or following changes in mental health status or newly Level II qualifying diagnosis. The Administrator will review the PASARR Audit Tool weekly for 12 weeks then monthly x 3 months to ensure all areas of concern are addressed to promote compliance. The results of the PASARR Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI Committee will meet monthly and review the PASARR Audit Tool to determine the need for ongoing monitoring or further intervention to ensure compliance. Completed: 12/18/2023	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident	F 808	F808	12/18/23

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F 808	Continued From page 16 interview, and staff interviews, the facility failed to provide a resident with a regular texture diet to reflect the active physician diet order for 1 of 4 residents reviewed for food (Resident #2). The findings included: Resident #2 was admitted to the facility on 3/09/20 with diagnoses which included diabetes, end stage renal disease, and dependence on dialysis. Resident #2 was hospitalized on 10/28/23 and returned to the facility on 10/31/23. Review of the discontinued/completed physician orders revealed Resident #2's prior diet order dated 7/26/23 was a controlled carbohydrates/no added salt diet, regular texture. The order was discontinued on 10/28/23 when he was hospitalized. A physician diet order dated 10/31/23 for a carbohydrate controlled no added salt diet, regular texture. The dietary communication slip dated 10/31/23 revealed the diet order sent to the dietary department for Resident #2 was for a carbohydrate controlled no added salt diet, regular texture. The Minimum Data Set (MDS) admission assessment dated 11/06/23 revealed Resident #2 was cognitively intact. Resident #2 was not coded for a swallowing disorder and was not coded for a mechanically altered diet. During an interview on 11/28/23 at 10:47 am Resident #2 revealed he did not like the way the facility served the meat on his meal trays. He	F 808	1. On 11/29/23 Resident #2 dietary meal ticket was immediately updated to reflect therapeutic diet prescribed by the physician. 2. On 12/11/23, all residents in the facility with physicians' orders for diets were identified as having the potential to be affected by this alleged deficient practice. A 100% audit of all residents with diet orders was performed to ensure the accurate diet is reflected on the dietary meal tickets. The administrator will be notified immediately of any concerns for resolution and all discrepancies updated for accuracy. 3. On 12/11/23, the administrator initiated an in-service educating the Dietary Manager and the Dietary dept. regarding the Dietary dept. updating resident meal ticket upon receipt of dietary communication ticket from the nursing dept. upon admission and prescribed diet modification's/changes. Additionally, the Dietary Dept. was educated that the physician's orders in the electronic medical record and the Dietary Tray Ticket electronic system interface overnight daily. The education further included that Dietary Staff are to print meal tickets daily and not to change or update a meal ticket without a dietary communication ticket from the nursing dept. Education will be completed by 12/15/23. All new dietary staff will receive the education upon hire and any staff that	

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F 808	Continued From page 17 stated the meat tasted like sand and he could not tell what kind of meat he was eating because it was ground up so small. Resident #2 stated it made him sick to his stomach just to look at it. An observation on 11/29/23 at 8:55 am of Resident #2's breakfast meal tray revealed his breakfast meat was ground into small pieces. Resident #2's breakfast meal ticket on his meal tray was reviewed and the diet was listed as regular texture, but it was crossed out and soft was handwritten in place of regular texture on the meal ticket. An interview was conducted on 11/29/23 at 4:18 pm with the Dietary Manager who revealed the nursing department entered the physician order in the medical record and would give the dietary department the diet communication slip and he would enter the order into the meal ticket program. The Dietary Manager stated he wrote soft on the meal ticket because he thought Resident #2 was a mechanical soft diet. He stated he did not recall receiving the diet communication slip for Resident #2's regular texture diet and did not recall him being on a regular texture diet prior to his hospitalization. He stated he meant to talk to the nurse regarding the order, but he had forgotten. The Dietary Manager stated the diet communication slip for Resident #2 must have been missed. During an interview on 12/01/23 at 9:34 am the Unit Manager revealed when Resident #2 was readmitted to the facility on 10/31/23 his diet order was entered, and a diet communication slip was sent to the dietary department. An interview was conducted with the	F 808	has not been educated by 12/15/23 will not be assigned to work until education is completed. 4. The dietary manager and/or administrator will review 10 resident meal tickets, weekly times 4 weeks then monthly times x 3months utilizing the dietary meal ticket audit tool. This audit is to ensure resident meal tickets accurately reflect the prescribed diet order and the resident is receiving the correct therapeutic diet. The Administrator will review the audit took weekly to address areas of concern identified during the audit for intervention. 5. The results of the Diet Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the PASARR Audit Tool to determine the need for ongoing monitoring or further intervention to ensure compliance. Compliance: 12/18/2023	

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F 808	Continued From page 18 Administrator on 12/01/23 at 10:07 am who revealed the Dietary Manager was responsible to ensure the correct diet texture for Resident #2 was entered in the meal ticket system when the diet communication slip was received from the Unit Manager.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview the facility failed to keep kitchen equipment clean by failing to clean 1 of 1 plate warmer, 1 of 1 drink nozzle, 1 of 1 knife holder, and 1 of 1 steam table shelf observed. This practice has the potential for cross contamination of food served to residents.	F 812	F812 Address how corrective action will be accomplished for these residents found to have affected by deficient practice: 1. On 11/2923 The Dietary Manager immediately cleaned the dirty equipment: Plate warmer, drink nozzle, knife, and the steam table shelf.	12/18/23

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F 812	Continued From page 19 The findings included: a. Observations of the kitchen were conducted on 11/28/23 at 9:53 AM, 11/29/23 at 3:06 PM and on 11/30/23 at 8:29 AM the two cylinder well plate warmer was observed with dark black dried food particles inside each well. b. Observations of the kitchen conducted on 11/28/23 at 9:53 AM and 11/30/23 at 10:41AM, the drink gun nozzle was observed with a buildup of sticky liquid. c. Observations of the kitchen conducted on 11/29/23 at 3:06 PM and 11/30/23 at 8:29 AM revealed a buildup of dried food particles on top of the wall mounted knife holder. An observation of the kitchen was conducted with the Dietary Manger on 11/30/23 at 10:41 AM. The 5-foot steam table shelf was observed to have a buildup of dark sticky food debris. The plate warmer, drink gun nozzle and knife holder were observed in the same condition. During an interview with the Dietary Manager on 11/30/23 at 11:48 AM he stated he had one staff at night to deep clean the kitchen and he did not always check behind to see the work was completed. He indicated he had a cleaning schedule and it was not always posted. In an interview on 12/1/23 at 9:37 AM the Administrator stated dietary should have a daily cleaning schedule and follow it. She further indicated she expected staff to clean the affected areas.	F 812	Address how the facility will be identify other resident having the potential to be affected by the same deficient practice: 2. Residents residing in the facility who receive meals from the Dietary Department, or the nourishment refrigerators have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: 3. On 12/11/23 The dietary Manager and Dietary Staff was educated by the Nursing Home Administrator (NHA) that all dietary equipment is to be cleaned according to the cleaning schedule. The dietary manager is expected to ensure the cleaning scheduling is readily posted follow up to ensure equipment has been cleaned appropriately. Prior to using dietary equipment, the dietary staff is expected to ensure the equipment is clean and sanitary. Indicate how the facility plans to monitor its performance to make sure that compliance is sustained: 4. The NHA, Dietary Manager or designee will conduct observational audits to validate that food service equipment is clean, cleaning schedule is available for all staff to review, and food service equipment is being cleaned appropriately. The audits will be conducted 2 x a week for 12 weeks. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make	

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F 812	Continued From page 20	F 812	recommendations to assure compliance is sustained ongoing. Compliance: 12/18/2023	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		12/18/23

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systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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F 867	Continued From page 22 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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	345063	A. BUILDING _____ B. WING _____	C 12/01/2023

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F 867	Continued From page 23 Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the complaint investigation surveys of 6/3/21 and 11/4/21 and the recertification and complaint investigation surveys of 4/16/21 and 8/19/22. This was for five deficiencies recited on the current recertification and complaint investigation survey of 12/1/23 in the areas of: Accuracy of Assessments (F641), Care Plan Timing and Revision (F657), Food Procurement, Storage and Preparation (F812), Complete and Accurate Medical Records (842), and Proper Functioning of Call System (F919). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: a) F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Gradual Dose Reduction, insulin administration, and antipsychotic medication for 3 of 26 sampled residents (Resident #57, Resident #61, and Resident #58). During a recertification and complaint investigation survey of 4/16/21 the facility inaccurately coded the use of insulin for a non-diabetic resident and an invasive mechanical ventilator on the MDS assessment. During a recertification and complaint	F 867	F867 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/11/23 the Regional Vice President of Clinical Services educated the Nursing Home Administrator and Director of Nursing on developing and maintaining an effective Quality Assurance and Performance Improvement Program. August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 12/11/23 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 12/11/23, under the direction	

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F 867	Continued From page 24 investigation survey of 8/19/22, the facility failed to accurately assess the discharge location on the MDS assessment. b) F657: Based on record review and staff interviews, the facility failed to update a resident care plan to reflect the resident's current nutritional status for 1 of 26 residents whose care plans were reviewed (Resident #2). During a recertification and complaint investigation survey of 4/16/21 the facility failed to conduct a care plan meeting and invite the resident to the care plan meeting. During a recertification and complaint investigation survey of 8/19/22, the facility failed to conduct a care plan conference. c) F812: Based on observations, and staff interview the facility failed to keep kitchen equipment clean by failing to clean 1 of 1 plate warmer, 1 of 1 drink nozzle, 1 of 1 knife holder, and 1 of 1 steam table shelf observed. This practice has the potential for cross contamination of food served to residents. During a recertification and complaint investigation survey of 4/16/21 the facility failed to remove expired items from a nourishment refrigerator. During a recertification and complaint investigation survey of 8/19/22, the facility failed to date left over food items, remove expired food stored for use and clean a nourishment refrigerator located in the day room. d) F842: Based on the record review, staff	F 867	and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the, MDS Coordinator (MDSC), Maintenance Director, and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. During the QAPI Meeting, the Committee decided to initiate weekly QAPI Meetings to review the status of the plan of correction for F641-Accuracy of Assessments, F657- Care Plan timing and Revision, F812- Food Procurement, storage & preparation, F842- Complete and accurate Medical Records, and F919-Proper Functioning of Call System as repeat deficiencies. Indicate how the facility plans to monitor its performance to make sure that compliance is sustained: An Ad Hoc QAPI meeting was held on 12/12/23 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, Admissions Director, Regional Vice President of Clinical Services and Regional Vice President of Operations. The QAPI Committee will meet weekly for twelve weeks beginning on 12/18/23, then monthly ongoing, to	

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F 867	Continued From page 25 interviews and Director of Nursing interview the facility failed to document complete and accurate information in the Medical Administration Record for one of twenty-six Residents (Resident #8) reviewed for accuracy of medical records. During a complaint investigation survey of 6/3/21 the facility failed to maintain accurate Medication Administration Records. During a complaint investigation survey of 11/4/21 the facility failed to maintain accurate Treatment Administration Records. e) F919: Based on observation, staff interviews, and resident interview, the facility failed to ensure a call light was functioning properly for one of one resident who required staff assistance for activities of daily living (Resident #33). During a recertification and complaint investigation survey of 4/16/21 the facility failed to ensure a call bell was working. An interview was conducted with the Administrator on 12/1/23 at 12:00 P.M. The Administrator revealed she was under the impression the plan of corrections were implemented. She also stated there has been complete change of administration staff to include the Director of Nursing and the Assistant Director of Nursing and she believed the transition of change caused a breakdown in the monitoring and audits that were in place previously. She stated the monthly Quality Assurance and Performance Improvement (QAPI) meetings have an agenda to ensure the QAA process is adhered to and monitored.	F 867	monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. Corporate oversight will be provided in the center's Quality Assurance Performance Meeting to assist the facility in achieving and maintaining compliance. The QAPI Committee determined that the facility is in substantial compliance as of 12/18/23. The Administrator is responsible for ensuring this plan of correction is implemented. Date of Compliance: 12/18/23	

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F 919	Continued From page 26	F 919		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and resident interview, the facility failed to ensure a call light was functioning properly for 1 of 1 resident who required staff assistance for activities of daily living (Resident #33). The findings included: Resident #33 was admitted to the facility on 10/14/23. Review of an admission Minimum Data Set assessment dated 10/18/23 documented Resident #33 had intact cognition. In an interview with Resident #33 during the initial tour of the facility on 11/28/23 at 9:30 AM he stated his call bell had never worked since his admission. He explained if he needed help, he would stand in his doorway and holler but would prefer to ring his call bell. He did not report the call bell was not working. On 11/28/23 at 10:30 AM an observation of the call bell in Resident #33's room revealed the call	F 919	F919 Address of corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 11/29/23 the Broken call light immediately resolved for resident #33. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 2. All residents have the potential to be affected by improper call light function. On 11/29/23 An audit of 100% of resident call lights was conducted to ensure accessibility and proper functioning. Measures the facility will take to ensure the problem will be corrected and will not reoccur: 3. On 11/30/2023 The Maintenance Director provided education to all staff, including the agency, regarding notifying the Maintenance dept. of improperly functioning call lights and maintenance concerns to be addressed. All staff will be educated by 12/15/2023. After 12/15/2023	12/18/23

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F 919	Continued From page 27 bell did not activate the light over his doorway and no sound was heard. The Director of Nursing was present during the observation. Several call lights in surrounding rooms on the hallway were checked and they were observed to produce sound and had a light over the doorway that was activated. In an interview with the facility Maintenance Director on 11/29/23 at 2:20 PM he stated he had no idea the call bell in Resident #33's room was broken. He stated when a repair was needed it was communicated on a work order slip. He reported that usually if there was something broken, if the nurse aide or nurse remembered to tell him when they passed him in the hallway and before they went off shift, he wrote it down on a slip of paper he carried in his pocket to remind him. He noted he had fixed the call bell in Resident #33's room after it was brought to his attention by the Director of Nursing on 11/28/23. He stated it wasn't the call bell cord in the room that was broken, it was a short in the electrical wiring leading to the light in the hallway above the doorway. In an interview with Nurse Aide #4 on 11/29/23 at 3:00 PM she stated she routinely cared for Resident #33. She noted she was not aware the call bell in his room was not working. She reported when Resident #33 needed something he would stand in his door and yell. She concluded had she known the call bell in his room was broken she would have written it in the book at the nurse's station and told the Maintenance Director when she passed him in the hallway. In an interview with Nurse Aide #5 on 11/29/23 at 3:10 PM she stated she normally cared for	F 919	any staff that has not been educated will not be permitted to work until education has been provided. 4. Indicate how the facility plans to monitor its performance to make sure that Compliance is sustained: 5. The maintenance Director or designee will conduct call light function audits, completing 10 call light audits per weekly x 12 weeks, then 10 call light audits a month x 8 weeks. Any issues or concerns will be reported to the Administrator for intervention and/or resolution. The Administrator will bring results to Quality Assurance Meeting (QAPI) monthly to determine the need for ongoing monitoring or further intervention to ensure compliance. Compliance: 12/18/2023	

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F 919	Continued From page 28	F 919		

Resident #33 on her assignment for the past couple of months. She noted she did not know his call bell had not been working because he had been coming to his doorway and asking for help when he needed it. She reported the resident had never told her his call bell was broken. She stated she completed incontinent rounds every 2 hours and checked the resident frequently. She commented that when she was aware of a needed repair, she would write it in the book at the nurse's station and tell the Unit Manager. It was her understanding the Unit Manager then would tell the Maintenance Director.

In an interview with the Unit Manager on B Hall on 11/29/23 at 3:20 PM she stated no one had informed her that the call bell in Resident #33's room had not been working since his admission.

In an interview with the facility Administrator on 12/1/23 at 8:05 AM she stated she would expect staff to know when a call bell was not working and to complete a work order slip so that maintenance could fix it. She would also expect to be notified if it was not fixed after filing a work order. She stated she was not aware Resident #33's call bell had not been working since his admission to the facility.